STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	67662	A. BUILDING: _____ B. WING _____	C 12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL PINES SENIOR LIVING	1760 TABLEROCK ROAD RAPID CITY, SD 57701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 12/29/25 through 12/31/25. Areas surveyed included nursing services, potential resident abuse and neglect, and pharmacy services. Peaceful Pines Senior Living was found not in compliance with the following requirements: S337 and S838.	S 000		
S 337	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: A. Based on review of South Dakota Department of Health (SD DOH) facility-reported incidents (FRIs), interviews, record review, and policy review, the provider failed to ensure: *Resident 1 was assessed with vital signs after a fall and a change of condition was reported to the on-call nurse. *Resident 3's abnormal vital signs were reported to the on-call nurse for guidance after a fall. *Policies were followed to meet professional standards of practice for two of two sampled residents (1 and 3). Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed:	S 337	**Past deficient practices are unable to be corrected. All residents have the potential to be affected by this deficient practice.** **All staff will be educated on the community's Fall Response and Change in Condition policies by 2/13/26. Education will be documented, and policies and procedures have been made available to staff. The communities on call schedule was updated to include a Licensed Nurse on call 24/7, 365 days per year. All falls and changes in condition will be reported to a Licensed Nurse per policy. The Fall Checklists were revised to match the community's Fall Response policy and will continue to be used as a guide to ensure all steps are followed with each fall. Each reported/documented fall and change in condition will be handled following policy. Each incident will be audited weekly for 6 weeks, bi-weekly for 1 month and monthly for 2 months by the Director of Nursing (DON) or Designee to ensure the Fall Response and Change in Condition policies were followed as well as any documented, planned follow up, corrective action, or audits were completed.**	02/13/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Krista Dittus

TITLE: Executive Director

(X6) DATE: 01/30/2026

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S 337	Continued From page 1 *She had a brief interview of mental status [BIMS] score of 5. That score indicated that she had severe cognitive impairment. *She was independent with walking did not require need for mobility assistive devices at baseline. * She was discovered lying on the floor in her room by resident care aide (RCA) D on 9/12/25 at 10:30 p.m. Her vital signs [a measure of blood pressure, heart rate, temperature, oxygen saturation, and respirations] were checked and within normal limits. She denied pain or hitting her head during that fall. -There was no documentation that the on-call nurse was called to report that fall. -Resident 1 was helped back to bed by RCA D. *RCA D checked on resident 1 again on 9/13/25 at 12:30 a.m. and resident 1 was lying on the floor next to her bed. Her head was next to her nightstand. -There was no documentation that the on-call nurse was called to report the second fall. -There was no documentation that resident 1's vital signs were checked after the second fall. -RCA D helped resident 1 back to bed. *RCA D checked on resident 1 ten minutes later on 9/13/25 at 12:40 a.m. and resident 1 was found on the floor next to her bed. -There was no documentation that resident 1's vital signs were checked after the third fall. -RCA D helped resident 1 back into a recliner and noted that she was unsteady on her feet at that time. -The recliner with resident 1 sitting on it was then wheeled out to the commons room for staff to be able to more closely monitor her. *The on-call nurse, registered nurse (RN) E, was notified of resident 1 having had three falls. The time of the call was not documented. *On 9/13/25 at 4:30 a.m. RCA F noted that	S 337	**Any deviation from either policy will be addressed at the time of the finding and corrected. These audits will include that timely follow up and corrective action has occurred with each incident. Results of these audits will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee comprised of the Interdisciplinary Team (IDT) including the Executive Director (ED), DON, Assistant Executive Director, Director of Culinary Services, Life Enrichment Coordinator, Business Office Manager, Memory Care and Assisted Living Nurse Managers, Staff Coordinator, Maintenance Director, Pharmacy Consultant, Registered Dietician, and Housekeeping Supervisor at the quarterly meetings by the DON or Designee for further review and recommendations. Documentation of the QAPI committee meetings will be reported to the governing body quarterly.** **All staff will be educated on the community's Medication Reconciliation and Medication Security and Accountability policies by 2/13/26. Education will be documented and policies and procedures have been made available to staff. All Unlicensed Medication Aides (UMA) will complete competencies by 2/13/26. Competencies will be documented and stored in each employee's personnel file. The ED or Designee will audit all employee files by 2/13/26 to ensure all currently employed UMA's have demonstrated medication administration competency via a documented competency checklist. The ED or Designee will audit employee files annually thereafter indefinitely to ensure all UMA's have completed annual competencies.**	

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S 337	Continued From page 2 resident 1 had some drooping on one side of her face. RCA F checked resident 1's vital signs and called the on-call nurse, RN E. -*RN E told RCA F to notify resident 1's power of attorney (POA) and continue to monitor resident 1 closely. RCA F left a voicemail message for the POA to call back to the facility to discuss the resident's change of condition. *On 9/13/25 at 6:30 a.m. unlicensed medication aide (UMA) G reported to RN E that resident 1 was increasingly weak on her left side and requiring extensive staff assistance from a sitting to a standing position. *Resident 1's POA was called again and said he would come to the facility later in the morning to see her. He arrived at 9:30 a.m. *Resident 1 was admitted to the hospital on 9/13/25 with the new diagnosis of a stroke. Interview on 12/31/25 at 12:13 p.m. with assistant executive director (AED) A revealed: *Executive director C was out of the facility on medical leave. *AED A would expect a resident's vital signs to be checked after every fall. She would expect those vital signs to be done before moving the resident. *She would expect the on-call person to be contacted with every fall. *She agreed that not checking vital signs or contacting the on-call person was not following the provider's policy. *She agreed that checking the vital signs may have detected a change of condition sooner. *She agreed that the change in resident's mobility from independent with ambulation to requiring extensive assistance to stand was a change of condition for that resident. *She would have expected the on-call nurse to come to the facility to assess the resident. *The change of condition and new facial drooping	S 337	**Results of these audits will be reported at the quarterly QAPI meetings by the ED or Designee for further review and recommendations by the IDT. Documentation of the QAPI committee meetings will be reported to the governing body quarterly.** **All new admissions and re-admissions will be audited within 1 week of admission or re-admission by the DON or Designee for 3 months to compare medications brought by the resident or supplied by pharmacy with medications ordered by the prescriber to identify and correct any discrepancies. Home medications will only be accepted in special circumstances, and these medications will be sent to pharmacy for review and verification prior to being used. Controlled substances will all be in a bubble pack and supplied by pharmacy. Also, the pharmacy enters all medication orders now that we switched electronic medical records systems in December 2025, and they complete medication review audits on all residents including new admissions and re-admissions. This process will continue as well as the DON or Designee auditing new admission and re-admission orders for order accuracy. Results of these audits will be reported to the QAPI Committee at the quarterly meetings by the DON or Designee for further review and recommendations by the IDT. Documentation of the QAPI committee meetings will be reported to the governing body quarterly.**	

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S 337	Continued From page 3 would have warranted a 911 call if the POA had not answered right away. Interview on 12/31/25 at 1:17 p.m. with director of nursing (DON) B revealed: *She had been in her DON role for one month and was still learning the provider's policies. *She would have expected vital signs to be checked with every fall and the on-call person to be notified with every resident fall. *She agreed that the resident may not have been able to accurately report a head injury with a BIMS of 5. If she noticed a resident's head next to a nightstand then she would assume that the resident hit their head as a precaution. *She would have expected the staff to perform further intervention and call 911 if the POA was unable to give direction on wishes for medical treatment. Review of the provider's 12/9/24 Fall Response policy revealed: *"If a fall occurs when a licensed nurse is in the building/available, staff will not move the resident and call the nurse to perform as assessment and determine next steps." * "If a fall occurs when a licensed nurse is not in the building/available to complete physical assessment" then the staff would be expected to ask the resident about injury, ask if they hit their head, and "obtain vital signs before the resident is moved". Review of the provider's 8/1/22 Change of Condition policy revealed: *The provider defined a change in condition as a "change from their baseline health or function." Examples given in the policy included "change in mental or physical function." *Residents were to be routinely monitored and if	S 337		

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S 337	Continued From page 4 there were a change in condition then the staff were to notify an on-call person/nurse. *"If the nurse is not in the building, the nurse will give the unlicensed staff member direction as to what immediate treatment or monitoring should be implemented." 2. Review of the 2/7/25 SD DOH FRI revealed: *Resident 3 sustained an unwitnessed fall on 2/7/25 at 2:50 a.m. in her room, near her bed. *Vital signs were taken at the time of the fall and were: BP (blood pressure)189/85, HR (heart rate) 69, R (respirations) 18, T (temperature) 98.1, O2 (oxygen) 94%. *"BP: initially elevated at 189/85 but returned to 146/60 with no complications." *"On call nurse was notified at the time of the fall and vitals were obtained at the time of the fall and shared with on call nurse [registered nurse (RN) E] which is what our policy instructs so it was followed." The facility's incident audit report for resident 3 was reviewed and indicated that RN E was not notified of the fall by UMA J until 6:15 a.m., over three hours after the fall. Review of resident 3's EMR revealed: *The documented vital signs indicated that resident 3's blood pressure was not rechecked until 8:43 a.m., nearly six hours after the initial elevated reading. At that time, it was recorded as 146/60, as referenced above. *Resident 3 had a change in condition later that morning. -She was sent out to the hospital and was diagnosed with a stroke. Interview on 12/30/25 at 1:59 p.m with assisted living nurse manager I regarding resident falls	S 337		

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S 337	Continued From page 5 revealed: *They utilized a fall checklist when a resident fell and initialed each line as that task was completed, which would guide staff members through the process. *If a resident care aide (RCA) found a resident who had fallen, they would call the unlicensed medication aide (UMA), who would come and initiate the fall checklist. *If a nurse were in the building, the nurse would assess the resident. *If there was no nurse in the building, the on-call person would be notified. Many staff members shared the call, not all of whom were nurses. * Vital signs would be documented in the EMR. *If vital signs fell outside the parameters on the fall checklist, a nurse would be notified for guidance. A copy of the Fall Checklist and Post Fall Vitals Sheet, which would have been in use at the time of resident 3's 2/7/25 fall, were requested on 12/30/25. No documentation was provided. Interview on 12/31/25 at 12:13 p.m. with AED A regarding the process following a resident fall revealed: *The staff member who found the resident stays with them, calls another staff member to bring the vital signs machine, and then checks the resident's vital signs. The staff members would perform a check of the resident by asking about pain and whether they hit their head. *The staff member would then call the nurse if the nurse was in the building or call the on-call person if the fall happened at night. If the on-call person was not a nurse, they would sometimes reach out to a nurse. *She would expect staff to recheck the vital signs that are outside of parameters. She would have	S 337		

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S 337	Continued From page 6 them wait five or ten minutes after a fall and then recheck. *Staff could notify the on-call person using their "Home Base" (team messaging system) or personal cell phone. *She would expect the on-call contact to be documented in the EMR. -She confirmed that contact was not documented for resident 3's fall. *She confirmed that no guidance was provided regarding the elevated blood pressure after resident 3's fall, or if such guidance was given, that it was not documented. *She agreed that resident 3's vital signs were outside the parameters of the policy and confirmed that UMA J should have contacted RN E sooner than 6:15 a.m. Interview on 12/31/25 at 1:17 p.m. with DON B revealed: *She had been the DON since 12/1/25. *If a resident fell when a nurse was in the building, the nurse would assess the resident at the time of the fall. If a nurse is not in the building, the on-call person is notified, and if the resident has no obvious injuries, a nurse will assess the resident right away in the morning. *Vital signs and an incident report would be documented in the EMR, and she thought there was a "fall sheet" that staff would use to document a fall. *She would have expected UMA J to notify RN E at the time of the fall. *She confirmed that the blood pressure was outside of parameters and needed nurse guidance, and she would have expected a re-check of vital signs earlier. Review of the provider's 12/9/24 Fall Response Policy revealed:	S 337		

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S 337	Continued From page 7 *"If a fall occurs when a licensed nurse is not in the building/available to complete physical assessment: -a. Ask the resident if they are alright. Check for obvious signs of injury or inability to move arms and legs without pain. -b. Ask the resident if they hit their head. Check for bumps, bruising, or bleeding. -c. Obtain vital signs before the resident is moved. Call nurse for vital signs outside of standard parameters listed below, for vitals outside of individual parameters set by resident's provider." *"Standard parameters: -B/P is greater than 160/90 or less than 100/45. -Heart rate greater than 100 or less than 50. -O2 saturation less than 90%. -temperature greater than 100.6° (or two degrees above baseline temperature)." *"If the resident is unable to get up by themselves: -i. Contact nurse on call and report resident fall, VS and symptoms of injury/pain, if any. -ii. Review symptoms and VS with nurse and obtain any additional information nurse requests. -iii. If nurse states it's OK to get resident up, and if they do not have any pain or apparent injury, ask the resident if they can get up." *"The nurse or the person who found/witnessed the fall will initiate the incident report and complete the Post Fall investigation report in PointClickCare." *"Complete Fall Checklist and return to DON/designee per facility policy." *"Document initial fall vitals in PointClickCare and put in nursing order for post fall vital signs." X. Review of the provider's 8/1/23 Change of Condition Policy revealed: *"Policy: Location will appropriately identify and address resident changes in condition to ensure	S 337		

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S 337	Continued From page 8 the safety of residents in the assisted living environment." *"Definition: -Change in Condition: The resident has had a change from their baseline in health or function. Observations that may indicate a change in condition may include change in mental or physical function, abnormal vital signs, increased her new behaviors, changes in appetite or pain levels, for example." *"Procedure: -Residents will be routinely monitored by employees who are responsible to notify the on call person/nurse of any changes in condition. --Notify licensed or registered nurse of the condition change, vital signs and any interventions taken." *"Documentation in the medical record will include -Date and time of condition change -Resident symptoms and interventions -Steps taken to ensure resident safety -Vital signs -Persons notified of condition change and directions, including notification date/time of the nurse, family/POA/guardian, and/or provider." Review of the provider's Fall Checklist revealed: *"Notify ON DUTY nurse or ON CALL nurse. If no obvious signs of injury or vitals are in parameters, text the on call nurse between 10pm and 7am. If vitals are out of parameters or resident hit their head or resident is on blood thinners, it is a MANDATORY CALL to the on call/duty nurse at the time of the fall." *"Parameters: (Before calling on call, take blood pressure and pulse on both arms if out of parameters) -Blood Pressure - either number greater than 160/90 or either number lower than 100/45.	S 337		

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S 337	Continued From page 9 -Heart Rate - greater than 100 or less than 50." *"Start Post Fall Vitals Sheet." B. Based on review of South Dakota Department of Health (SD DOH) facility-reported incidents (FRIs), interviews, record review, and policy review, the provider failed to ensure one of one sampled resident (2) was given the correct medications. Findings include: 1. Review of the 12/10/24 SD DOH FRI regarding resident 2 revealed: *Resident 2 was admitted to the facility on 9/16/24. *One of the provider's admission medication orders was for Metoprolol succinate (a medication used to treat heart conditions by slowing the heart rate and relaxing blood vessels) 25mg with the instructions to give 0.5 (12.5 mg) tablets every evening. -The bottle of Metoprolol succinate that the resident brought from home on admission had the instructions to give 0.5 tablets (12.5 mg) every evening. *The order was incorrectly put into resident 2's electronic medical record (EMR) as give 1.5 tablets every evening. *On 12/9/24 resident 2 complained of not feeling well. -He was admitted to the hospital later that day for a new diagnosis of bradycardia (low heart rate). Review of resident 2's EMR revealed: *He had an order from his provider to take Metoprolol Succinate ER 25mg with the instructions to take 0.5 tablets (12.5mg) daily on his admission orders. *His heart rate from 9/17/24 to 12/3/24 ranged	S 337		

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between 97 and 64 beats per minute [BPM].
*His heart rate on 12/9/24 was 44 BPM.

Review of the provider's undated action plan regarding the investigation conclusion of resident 2's medication error revealed:
*All admissions in the last six months were audited for accuracy.
-*Those audits would include random checks of medications in the medication cart compared to the resident's medication administration record (MAR), with a "special focus on residents who use bottled medications".
*Audits of medication administration would be completed daily for four weeks, then three times per week moving forward.
*The provider would no longer accept home medications when a resident was admitted.
*The provider would develop a training checklist for unlicensed medication aides (UMA).
*"Update/complete all UMA competencies (even those less than a year old)".
*The process for admission medication reconciliation would be discussed with the quality assurance and performance improvement (QAPI) team.

Review of the provider's January 2025 QAPI meeting notes revealed:
*"Competencies for UMAs are being completed for all new UMAs during training."
*The goal date to have all UMAs caught up on the competencies was 01/15/25.

Review on 12/30/25 at 3:36 p.m. of the provider's UMA employee files revealed that one out of 16 UMAs had a completed UMA competency checklist.

Interview on 12/30/25 at 2:25 p.m. with UMA O

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S 337	Continued From page 11 and UMA P revealed: *The residents were allowed to bring home medications upon admission. *The medications would go to the nurse on duty or the director of nursing for reconciliation with the resident's provider orders. Interview on 12/31/25 at 12:13 p.m. with assistant executive director (AED) A revealed: *Executive director C was out of the facility on medical leave. *The facility no longer accepted home medications. She was unaware that their policy included instructions for staff to perform with a resident's home medications. She agreed that this can be confusing to staff, especially if they were new to the facility. *She would have expected the UMA competencies to be up to date. *She agreed that the first low heart rate should have been reported to the on-call nurse, and that the low heart rate could have been considered a change in condition. *She agreed that the action plan had not been completed by the provider. Interview on 12/31/25 at 1:17 p.m. with director of nursing [DON] B revealed: *She had been at the facility as the DON for one month. *She could not find any documentation that the action plan was followed for resident 2's medication error. *She would have expected the action plan to be completed to prevent another medication error in the future. Review of the provider's 8/1/22 Medication Reconciliation policy revealed: *" Safe medication reconciliation procedures will	S 337		

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	67662	A. BUILDING: _____ B. WING _____	C 12/31/2025

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S 337	Continued From page 12 be followed to identify and resolve discrepancies before they can cause harm to a resident". *" Compare medications brought by the resident with medications ordered by their prescriber". *" Identify any discrepancies between medications brought by the resident with medications ordered for the resident".	S 337		
S 838	44:70:09:09(4) Quality Of Life A facility shall provide care and an environment that contributes to the resident's quality of life, including: 4) Freedom from verbal, sexual, physical, and mental abuse and from involuntary seclusion, neglect, or exploitation imposed by anyone, and theft of personal property; This Administrative Rule of South Dakota is not met as evidenced by: Based on review of South Dakota Department of Health (SD DOH) facility-reported incidents (FRIs), record review, interviews, review of personnel files, and policy review, the provider failed to ensure that a thorough investigation was completed, and their plan of correction was followed related to an allegation of potential abuse and neglect for two of two sampled residents (4 and 5). Findings include: 1.Review of a SD DOH 2/25/25 FRI revealed: *On 2/21/25 at 5:17 a.m., certified nurse aide (CNA) L reported to registered nurse (RN) K that	S 838	**Past deficient practices are unable to be corrected. All residents have the potential to be affected by this deficient practice.** **All staff will be educated on the community's Abuse and Neglect Investigation and Reporting policy and procedure by 2/13/26. Education will be documented and policies and procedures have been made available to staff. All alleged and substantiated abuse or neglect investigations will be reported internally and to the department and thoroughly investigated according to the required timeframes. A new incident reporting and documentation process has been implemented with an incident checklist to be completed to ensure a thorough investigation is completed. Once the checklist is completed by the DON or Designee, the ED or Designee will audit for completeness. If witnesses are to be interviewed, a witness statement will be recorded for each individual being interviewed to provide documented proof of the interview. If any incident occurs regarding abuse or neglect, all staff will be educated specifically on abuse and neglect within 30 days, and this education will be documented.**	**02/13/26**

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S 838	Continued From page 13 resident 5 had two skin tears, one on each arm, and a bruise to her right eye. CNA L stated she did not know how the injuries happened. *RN K assessed resident 5 at 5:30 a.m. on 2/21/25, noting: -An open 1.5 by 2.5 centimeter (cm) skin tear on the left lower forearm with no skin to approximate (injury caused by mechanical force, friction, or blunt trauma where the outer layer of skin, the epidermis, is completely lost or destroyed, leaving the wound bed exposed with no tissue available to cover the deeper layer, the dermis). -A 6 by 4 cm skin tear to the right wrist with patches of skin to approximate. -A 0.5 by 0.5 cm light purple bruise to the right lower, outer eyelid. *RN K treated the injuries and reported the injuries of unknown origin to the (previous) director of nursing (DON) N. *DON N did not fill out an incident report when she was notified of the injuries on 2/21/25, and did not notify executive director (ED) C of the incident until the afternoon of 2/24/25. *On 2/24/25, a 3 by 3 cm yellow, healing bruise was also noted on resident 5's left thigh, which the report attributed to the 2/21/25 incident. *ED C's investigation of the incident, which included a review of camera footage, concluded that resident 5 was free from injury at 4:00 a.m., and that CNA L was the only person to care for resident 5 until the injuries were discovered at 5:00 a.m. -After the facility's investigation, CNA L was terminated on 2/26/25. *All residents with a Brief Interview for Mental Status (BIMS) assessment score of 10 or higher (indicating moderate cognitive impairment) who could be interviewed were asked about their feelings of safety, feeling well cared for, and whether staff monitored them.	S 838	**All abuse or neglect investigations will be audited to ensure the incident checklist has been completed, a plan of correction was implemented and follow up has occurred per the plan of correction by the due date indicated by the ED or Designee for 3 months. Results of these audits will be reported to the QAPI at the quarterly meetings by the ED or Designee for further review and recommendations by the IDT. Documentation of the QAPI committee meetings will be reported to the governing body quarterly.** **All new staff will be screened per the community's Abuse and Neglect Investigation and Reporting policy and procedure. Background checks and licensure disciplinary checks will be completed on all new hires before completing new hire orientation and before they come in contact with a resident. The ED or Designee will audit all new hires for 3 months to ensure a background check and license check are completed prior to their hire date or any contact with residents ensuring the community does not employ individuals who have been convicted of abusing, neglecting, or mistreating another human being by a court or law; or have a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and will report any knowledge of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.**	

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S 838	Continued From page 14 *Several employees were also interviewed since many residents could not be interviewed. *All staff members were educated on the expectations of resident care and toileting. 2. Review of SD DOH 2/25/25 FRI revealed: *On 2/24/25, night shift CNAs L and M went room to room rounding on residents in the memory care unit (an area where specialized care is provided in a structured, safe, and supportive environment to meet the unique needs of residents with significant memory and cognitive decline, that is secured to minimize unsafe wandering) with the oncoming dayshift staff. At 6:08 a.m., they entered resident 4's room and found her standing at her bathroom sink, brushing her teeth. They noted she had a skin tear and some blood coming from her left arm. *RN K was called to resident 4's room for wound care, and when she arrived, CNA L reported that the resident was resting in bed during the 4:00 a.m. rounds, and staff had no idea how the skin tear occurred. -CNA M was assigned to provide overnight care and assistance to resident 4, but CNAs M and L split their assignment, and both provided assistance. *RN K cleaned the wound and put a dressing on it. She assessed the resident and found no other injuries. *The facility's investigation confirmed the abuse and neglect allegations against CNAs L and M. However, it was not confirmed that the abuse caused the skin tear, "due to lack of proof, although it seems likely one of them caused it." *Their review of camera footage showed CNA L and M did not toilet resident 4 or provide incontinence care for over eight hours, from 8:37 p.m. until 4:43 a.m. The CNAs did not check on	S 838	**Results of these audits will be reported to the QAPI at the quarterly meetings by the ED or Designee for further review and recommendations by the IDT. Documentation of the QAPI committee meetings will be reported to the governing body quarterly.**	

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S 838	Continued From page 15 resident 4 for over four hours. *CNA M was terminated on 2/26/25. *All residents with a Brief Interview for Mental Status (BIMS) assessment score of 10 or higher (indicating moderate cognitive impairment) who could be interviewed were asked about their feelings of safety, feeling well cared for, and whether staff monitored them. *Several employees were also interviewed since many residents could not be interviewed. *All staff members were educated on the expectations of resident care and toileting. 3. Review of the facility's investigation into the incidents revealed: *On 2/24/25, ED C reviewed the camera footage from 2/21/25, which showed: -Resident 5 and CNA L entered resident 5's room at 4:48 a.m. There were no skin tears on her arms at that time. -From her room, resident 5 then screamed, "Ow! Stop! Get away from me!" --The FRI indicated she sounded "very agitated," and "it appears that she gets hurt in some way." -CNA L exited resident 5's room at 4:52 a.m. -CNA L reentered resident 5's room at 4:53 a.m. and asked her what was wrong. She also stated, "I just got here, so I did not do anything to you." --The FRI indicated that resident 5 "is still hollering and saying get away from me at this time." -CNA L left the room at 4:56 a.m. -At 5:01 a.m., CNA L told resident care aide (RCA) Q that resident 5 had skin tears to both of her arms, and they both went into resident 5's room. -At 5:08 a.m., CNA L left resident 5's room to get supplies from the nurses' station and then returned. -At 5:11 a.m., RCA Q walked out of resident 5's	S 838		

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S 838	Continued From page 16 room. --The FRI indicated "you can hear that [resident 5] is still upset and did not want [CNA L] near her." -CNA L then left resident 5's room, and RCA Q stayed with resident 5, "to try to calm her down." -At 5:17 a.m., CNA L reported to RN K that resident 5 had skin tears. *ED C's review of the camera footage from 2/23/25 showed: -At 12:15 a.m., CNA M "forced [resident 5] into her room" and was "rough with resident physically" while CNA L yelled at the resident. -At 4:43 a.m., CNA L entered resident 4's room and "changed her brief or emptied trash." -At 6:08 a.m., the group of staff members was doing rounds, entered resident 4's room, and discovered the skin tear. *On 2/25/25, ED C interviewed CNA L. CNA L: -Did not know why resident 5 screamed, "Ow! Stop! Get away from me!" and said, "She just started doing that." -Did not know what caused resident 4's skin tear. -Did not deny neglecting resident care. *On 2/25/25, ED C interviewed CNA M. CNA M: -Did not know anything about resident 5's skin tear. -She did not know what caused resident 4's skin tear. -Admitted to not providing resident care per policy. -Admitted to escorting resident 5 to her room roughly and speaking sternly, "telling her to get in her room and get her clothes on." *There was no evidence that any resident interviews had been conducted. -The facility was unable to provide any such	S 838		

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S 838	Continued From page 17 documentation. *Only one employee was interviewed. That employee reported another incident of CNAs L and M being verbally aggressive with a resident on 2/23/25. 4. Review of the staff education provided following these incidents revealed: *On the 3/19/25 All Staff agenda, under Notes/Reminders: "Just a reminder, all residents must be checked on every 2-3 hours or more no matter what! They still need to be checked on when they are in their rooms. For example, a resident is napping or gets laid down for the night at 7pm, staff must still check on these residents in their rooms at least every 2-3 hours." -No education specifically about abuse was provided. 5. Review of CNA M's personnel file revealed that the facility did not provide evidence that it had reviewed this individual's history to ensure they did not knowingly hire someone with a conviction of abuse toward another individual. 6. Interview on 12/31/25 at 12:13 p.m. with assistant executive director (AED) A revealed: *She would expect any staff member who witnesses verbal or physical aggression towards a resident to report it to a supervisor. *She would have expected (previous) DON N to notify ED C of the first allegation of abuse, or investigate it and report it herself. *She believed that the second incident could have been prevented if the first allegation had been reported and acted upon. *She agreed that there was no documentation to indicate that any residents had been interviewed about their feelings of safety. *She agreed that there was no documentation	S 838		

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S 838	Continued From page 18 that more than one employee had been interviewed about the residents' safety following these incidents. *She was aware that CNA M's review to ensure she did not have a history of an abuse conviction was not completed. She stated she initiated the process, but did not confirm it was completed before CNA M started working. *She stated that education was provided to staff to prevent abuse in the future. -She acknowledged that no abuse-specific education was provided at the time of the incident, and that education related to abuse was only covered in the annual training, which happened in June 2025. 7. Interview on 12/31/25 at 1:17 p.m. with director of nursing (DON) B revealed: *She has been the DON since 12/1/25. *She would expect staff members who witness any type of abuse of a resident to notify someone immediately, and wants to make sure they are comfortable reporting it. *She would have immediately suspended the staff member over the abuse allegation, pending an investigation. *She would have reported the incident to the DOH within 24 hours. *She believed that the second incident could have been prevented if action had been taken after the 2/21/25 incident. 8. Review of the provider's 7/15/22 "Abuse & Neglect Investigation & Reporting Policy & Procedure" revealed: *"Procedures Statement -Staff members assess each patient or resident for signs of abuse, neglect, or exploitation at appropriate times; Assist with referrals to outside agencies for care when necessary; And report	S 838		

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S 838	Continued From page 19 cases of possible abuse, neglect, and exploitation internally and externally, as appropriate." *"Purpose -To establish standardized criteria for identifying suspected cases of abuse, neglect, and exploitation and procedures for assisting actual and suspected victims in seeking appropriate care to protect patients and/or residents and minimize the risk of harm." *"Definitions -"Abuse - Intentional mistreatment that may cause either physical or psychological injury. Includes the following:" --"Neglect - The absence of the minimal services or resources required to meet basic needs. Neglect includes withholding or inadequately providing medical care and, consistent with usual care, treatment, and services, food and hydration (without approval from the individual, physician, or surrogate), clothing or good hygiene. It may also include placing an individual in unsafe or unsupervised conditions." --"Physical abuse - Intentional mistreatment of an individual that may cause physical injury. Examples include hitting, slapping, pinching, or kicking, and may also include attempts to control behavior through corporal punishment." *"Considers the following when performing the screening:" -"Physical signs observed in the patient or resident, including but not limited to the following: --Unexplained or inconsistently explained injuries." -"Signs exhibited by the caregiver, including but not limited to the following:" --"Anger, indifference, aggression, or lack of affection toward the patient or resident" --"Conflicting accounts of incidents or injuries" *"The administrator or designee does the following:	S 838		

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S 838	Continued From page 20 1. Reports alleged or suspected cases of abuse, neglect, misappropriation or exploitation to the appropriate authorities as soon as possible, but not more than 48 hours after the incident is reported, according to law and regulation." 9. Review of the provider's 6/10/22 Abuse, Neglect, and Misappropriation Policy revealed: *"Policy: -Residents have the right to be free from verbal, sexual, physical, mental abuse, corporal punishment, neglect, misappropriation of residence funds or property, exploitation, and involuntary seclusion. Residents must not be subjected to abuse by anyone including, but not limited to, facility staff, consultants, volunteers, those representing other agencies, legal guardians, friends, or other individuals. This facility will not knowingly employ persons with abusive histories, and precautions will be taken to prevent this possibility and to respond appropriately should such situations arise." *"Definitions: -Abuse: Means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. This presumes that instances of abuse of all Residents, even those in a coma, cause physical harm or pain or mental anguish." -"Neglect: Means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes failure to carry out resident services as directed or ordered by the physician or other authorized personnel, failure to give proper attention to residents, or failure to carry out	S 838		

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S 838	Continued From page 21 resident services through careless oversight." *"Screening: Every department with staff that deals directly with residents will check all pertinent state nurse aid registries, other licensing authorities or character references to ascertain existence of abuse histories. This facility will not employ individuals who have been convicted of abusing, neglecting, or mistreating another human being by a court of law; Or have a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and will report any knowledge of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities."	S 838		