STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435132	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA BRULE NURSING HOME INC	408 SOUTH JOHNSTON STREET , WHITE LAKE, South Dakota, 57383

(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) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/26/26 through 7/29/26. Aurora Brule Nursing Home Inc was found not in compliance with the following requirements: F582, F583, F689, F712, F761, F812, and F847. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/26/26 through 7/29/26. The area surveyed was potential staff-to-resident abuse and neglect. Aurora Brule Nursing Home Inc was found not in compliance with the following requirements: F600 and F610.	F0000	The plan of correction prepared for this deficiency was executed solely because it is required by provision s of state and federal law. Without waiving the foregoing statement, the facility states that with respect to.	
F0610 SS = E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD	F0610	Administrator will complete root cause analysis. Administrator and Social services will review and revise investigation procedure as necessary. Administrator or designee will educate all department managers on incident investigation procedure. Administrator will audit all investigation procedures for completed investigative protocol forms from the past three months. Administrator or designee will audit future investigations making sure the investigation protocol procedure is complete monthly for three months and report to QAPI for further review and consideration.	09/09/2026

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 reverse for further 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
Kathleen Styles	Administrator	08/28/2026

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F0610 SS = E	Continued from page 1 DOH) facility-reported incident (FRI), interview, record review, and policy review, the provider failed to thoroughly investigate an allegation of abuse involving one of one certified nursing assistant (CNA) (V) who threw an incontinence brief at one of one sampled resident (8), told him to "do it yourself," and left him on the toilet without providing care. The provider's failure to conduct a thorough investigation placed the other residents at risk for abuse and neglect by not determining if similar incidents had occurred, or if additional residents were affected. The facility's census at the time of survey was 44. Findings include: 1. Review of the provider's 2/24/26 SD DOH FRI revealed that resident 8 reported to licensed practical nurse (LPN) U that a staff member was rude to him that evening. Resident 8 told LPN U that when he needed assistance in the bathroom, the staff member told him to "do it himself", gave resident 8 a brief, then left the room. Resident 8 was blind and was unable to provide the staff member's name. The provider interviewed all staff members who were scheduled to work at the facility that night and determined that CNA V was the staff member who provided care to resident 8 on the evening of 2/24/26. CNA V did not provide the resident's care according to the resident's care plan and substantiated the allegation of abuse. CNA V's employment with the facility was terminated on 2/26/26. 2. Interview on 7/29/26 at 10:37 a.m. with social services designee (SSD) D revealed that she interviewed resident 8 after the alleged abuse by CNA V. SSD D remembered speaking with resident 8 but was unable to interview CNA V as her employment was terminated. She stated that she did not interview other residents who were assigned to be cared for by CNA V to determine if any residents may have been abused by CNA V. She explained that she did not interview any other residents because "nobody else came to me." 3. Review of the provider's Investigative Protocol Form revealed that an investigation into the incident was initiated on 2/25/26. The protocol form included eight interventions to be completed for the investigation. Those interventions were: description of the issue, immediate action taken, root cause analysis, policy review, in-service education form,	F0610		

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F0610 SS = E	Continued from page 2 focus audit form, investigative summary, and care plan review. The intervention areas for root cause analysis, in service education form, and focus audit form were not completed on the investigative protocol form for the 2/24/26 incident. 4. Interview on 7/29/26 at 11:29 a.m. with director of nursing (DON) B and administrator A revealed that administrator A and SSD D usually investigated allegations of abuse. Resident 8's roommate was interviewed by administrator A after the report of abuse from resident 8's abuse by CNA V and resident 8's roommate did not hear the incident in the bathroom on 2/24/26 because he had headphones on. They confirmed that the root cause analysis, in-service education form, and focus audits were not completed on the investigative protocol form of the 2/24/26 incident. They stated that no other residents under CNA V's care were interviewed to determine the extent of abuse, and that another incident could have occurred between CNA V and another resident while she worked at the facility. 5. Further interview on 7/29/26 at 12:12 p.m. with administrator A revealed that staff education was provided at the all-staff meeting in March 2026 regarding abuse and neglect, but she could not provide a copy of that educational material. The staff education sign-in acknowledgement sheet included signatures of the staff members who attended that meeting, but not all signatures were legible to determine that all staff received the education on abuse and neglect. 6. Review of the provider's 1/14/26 Freedom from Abuse, Neglect, and Exploitation Policy revealed that the purpose of the policy was to "ensure that residents are not subjected to abuse by anyone," "to ensure all identified incidents of alleged or suspected abuse/neglect are promptly investigated," and to "ensure a complete review of existing incidents is documented." Investigation of abuse may include interviewing staff, residents, or other witnesses to the incident.	F0610		
F0712 SS = E	Physician Visits-Frequency/ Timeliness/Alternate NPPs CFR(s): §483.30(c)(1)-(4)	F0712	Administrator will complete root cause analysis. Administrator and Director of nursing will review and revise as necessary policy of Physician visits. Director of nursing or designee will educate all charge nurses, department managers, and resident's PCPs on the policy of Physician Visits.	09/09/2026

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F0712 SS = E	Continued from page 3 §483.30(c) Frequency of physician visits. §483.30(c)(1) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure that required physician visits (every 30 days for the first 90 days after the resident's admission and every 60 days thereafter) were alternated between personal visits by the physician and by the physician assistant (PA) after the physician makes the initial comprehensive visit for residents under a SNF stay (skilled nursing care covered by Medicare part A) for four of four sampled residents (4, 8, 29, and 43) who had SNF stays at the facility in the period reviewed from 7/4/25 through 7/29/26. Findings include: 1. Review of resident 8's electronic medical record (EMR) revealed that he admitted to the facility on 6/18/20. He had a SNF stay that began on 10/9/25 and ended on 10/30/25. PA C assessed resident 8 on 7/22/25, 8/12/25, 10/14/25, 11/26/25, 12/10/25, 2/4/26, 4/8/26, 5/27/26, and 7/22/26. There was no documentation in his EMR that indicated he had a medical visit completed by a physician within the last year. 2. Review of resident 29's EMR revealed he admitted to the facility on 11/7/25. He was assessed by PA C	F0712	Administrator or designee will audit appropriate services provided for three months, then quarterly x2 quarters and report to QAPI for further review and consideration.	

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F0712 SS = E	Continued from page 4 on 11/19/25 for his initial certification visit, 12/17/25 for his second certification visit, and 1/7/26 for his final 90-day certification visit. There was no documentation in his EMR that indicated he had a medical visit completed by a physician since he admitted. 3. Review of resident 4's EMR revealed she admitted to the facility on 4/29/24. She had a SNF stay that began on 3/16/26 and ended on 4/24/26 and another SNF stay that began on 5/10/26 and ended on 5/19/26. PA C assessed resident 4 on 7/8/25, 9/2/25, 10/1/25, 10/28/25, 12/23/25, 1/28/26, 4/8/26, 6/3/26, and 7/8/26. She was assessed by a physician on 2/11/26 for a hospital follow-up and on 6/30/26 for an acute issue. 4. Review of resident 43's EMR revealed she admitted to the facility on 3/23/26. She had a SNF stay that began on 3/23/26 and ended on 5/25/26. She was assessed by PA C on 3/25/26 for her initial certification visit, 4/22/26 for her second certification visit, and 5/20/26 for her 90-day certification visit. There was no documentation that indicated she had a physician visit or an examination completed by a physician since she admitted. 5. Interview on 7/28/26 at 11:21 a.m. with administrator A revealed that she thought that a non-physician practitioner (NPP), such as a PA, was allowed to see all of the residents for their standard medical visits. She was not aware that a physician was to conduct the resident's initial visit and every other 30-day physician visit after that for residents under SNF stays. 6. Interview on 7/29/26 at 11:15 a.m. with PA C revealed that she completed the residents' first provider visit after they admitted to the facility. She stated that a physician came to the clinic in town at least once a month, but she (PA C) usually saw the residents in the nursing home for their medical care and visits. She stated that there was always a physician on call and available to fill in for her if she was unavailable. 7. Review of the provider's undated Resident Policy Manual revealed that residents were required to have an examination by their physician prior to admission or within 48 hours after admission. After admission,	F0712		

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F0712 SS = E	Continued from page 5 residents would need to see their physician every 30 days for the first 90 days. 8. Review of the provider's April 2026 "Policy and Procedure for Physician Rounds" revealed that each resident would receive timely medical supervision by an attending physician, physician assistant, or nurse practitioner in compliance with federal and state laws.	F0712		
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review,	F0583	Social Services will complete root cause analysis. Social Services designee will review and revise policy on HIPAA and Resident Rights. Social Services or designee will provide education to CNA S on HIPAA and Resident Rights. Social Services or designee will provide education to all other staff and HIPAA and Resident Rights. Social Services or designee will audit HIPAA compliance and Resident Rights by watching and listening to staff weekly for four weeks and monthly for two months, then report to QAPI for further review and consideration.	09/09/2026

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F0583 SS = D	Continued from page 6 the provider failed to protect the residents' right to confidential personal medical information for two of two sampled residents (41 and 40) by one of one observed certified nurse aide (CNA) (S) who left residents' electronic medical records (EMR) information displayed on a computer screen mounted to the wall in the East hallway. Findings include: 1. Observation on 7/27/26 at 3:40 p.m. in the East hallway revealed CNA S was in the hallway entering data on a computer. She left the computer with resident 41's EMR information displayed on that computer screen and entered another resident's room. CNA S came out of that room and returned to the computer screen. She left the computer and answered another resident's call light at 3:42 p.m. with resident 40's EMR information displayed on the computer screen. CNA S came back out into the hallway and continued to use that same computer. At 3:46 p.m. CNA S left the computer to answer another resident's call light. The computer was left on a screen that displayed all the residents' names. At 3:50 p.m. CNA I walked down the hallway, paused and locked the computer screen, then continued down the hallway. 2. Interview on 7/27/26 at 3:55 p.m. with registered nurse (RN) Q revealed that the computer screens in the hallways were for staff members to use for charting the residents' care in the EMR system. She stated that when staff members were done using the computer, they were expected to lock the screen to protect the residents' private medical information. 3. Interview on 7/29/26 at 11:29 a.m. with director of nursing (DON) B and administrator A revealed that staff were expected to keep residents' medical information private by locking the computer screens when they were done charting in the EMR system. They agreed that any visitor or other resident could potentially use the computer's touch screen and access residents' medical information if the staff did not lock the screen. 4. Review of the provider's undated resident admission packet revealed a booklet called "Nursing Home Residents' Rights." The booklet stated that residents have the right to approve or refuse anyone outside of the nursing home access to their personal and care records.	F0583		

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F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on the South Dakota Department of Health (SD DOH) Facility Reported Incident (FRI), interview, record review, and policy review, the provider failed to protect the residents' right to be free from verbal and physical abuse for one of one sampled resident (8) who reported that he had an incontinence (involuntary urine or bowel leakage) absorbent brief thrown at him, was told to do it himself, and was left on the toilet without assistance by one of one certified nursing assistant (CNA) (V). Findings include: 1. Review of the provider's 2/24/26 SD DOH FRI revealed that resident 8 reported to licensed practical nurse (LPN) U that a staff member was rude to him that evening. Resident 8 told LPN U that when he needed assistance in the bathroom, the staff member told him to "do it himself", gave resident 8 a brief, then left the room. Resident 8 was blind and was unable to provide the staff member's name. The provider interviewed all staff members who were scheduled to work at the facility that night and determined that CNA V was the staff member who provided care to resident 8 on the evening of 2/24/26. CNA V did not provide the resident's care according to the resident's care plan and substantiated the allegation of abuse. CNA V's employment with the facility was terminated on 2/26/26.	F0600	Social Services will complete root cause analysis. Social Services or designee will review and revise abuse policy as necessary. Social Services or designee will educate all staff on abuse policy. Social Services or designee will complete audits on all complaints of abuse to ensure thorough investigation completed weekly for four weeks then monthly for two more months and report to QAPI for further review and consideration.	09/09/2026

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F0600 SS = D	Continued from page 8 2. Review of resident 8's electronic medical record (EMR) revealed that he admitted to the facility on 6/18/20. He had a 6/24/26 Brief Interview for Mental Status (BIMS) assessment score of 15 which indicated that his cognition was intact. He had diagnoses of reduced mobility, blindness, and lumber fusion (the surgical joining of two or more bones in the lower spine). Resident 8's 8/11/21 care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) had a focus area that indicated "[resident 8] is completely blind, unable to see shapes, shadows" with the intervention for the staff to assist the resident as needed with his activities of daily living (ADLs). Resident 8 had another 4/6/26 focus area that indicated "[resident 8] has an ADL self-care performance deficit" with the intervention for the staff to provide partial to moderate assistance with personal hygiene. 3. Interview on 7/27/26 at 10:58 a.m. with resident 8 revealed that he needed the staff's assistance with putting on a new incontinence brief due to his blindness, and difficulty bending over due to his history of back surgery. He remembered that a staff member "threw" a brief at him while he was on the toilet, and when he asked her for assistance with putting it on, she told him to "do it yourself," and then left his room. Resident 8 pulled his call light cord, and another staff member helped him put the new brief on and get off the toilet. Resident 8 was not sure of the staff member's name who threw the incontince brief at him. Resident 8 stated that incident was his only negative interaction with a staff member at the facility. He stated that CNA V did not introduce herself when she came into the room and he did not remember hearing her voice taking care of him after this incident. 4. Interview on 7/29/26 at 10:37 a.m. with social services designee (SSD) D revealed that she interviewed resident 8 after the alleged abuse by CNA V. SSD D remembered speaking with resident 8 but was unable to interview CNA V as her employment was terminated. She stated that she did not interview other residents who were assigned to be cared for by CNA V to determine if any residents may have been abused by CNA V. She explained	F0600		

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F0600 SS = D	Continued from page 9 that she did not interview any other residents because "nobody else came to me." 5. Review of the provider's Investigative Protocol Form revealed that an investigation into the incident was initiated on 2/25/26. The protocol form included eight interventions to be completed for the investigation. Those interventions were: description of the issue, immediate action taken, root cause analysis, policy review, in-service education form, focus audit form, investigative summary, and care plan review. The intervention areas for root cause analysis, in service education form, and focus audit form were blank on the investigative protocol form. 6. Interview and review of the Investigative Protocol Form on 7/29/26 at 11:29 a.m. with director of nursing (DON) B and administrator A confirmed that the root cause analysis, in-service education form, and focus audits were not completed in the investigative protocol form for the 2/24/26 incident. 7. Further interview on 7/29/26 at 12:12 p.m. with administrator A revealed that no audits of CNA V's interactions with residents or other staff interactions with residents were completed. Administrator A stated that staff education was provided at the all-staff meeting in March 2026 regarding abuse and neglect, but she could not provide a copy of that educational material. The staff education sign-in acknowledgement sheet included signatures of the staff members who attended that meeting, but not all signatures were legible to determine that all staff received the education on abuse and neglect. 8. Review of the provider's 1/14/26 Freedom from Abuse, Neglect, and Exploitation Policy revealed that the purpose of the policy was to "ensure that residents are not subjected to abuse by anyone," "to ensure all identified incidents of alleged or suspected abuse/neglect are promptly investigated," and to "ensure a complete review of existing incidents is documented." Investigation of abuse may include interviewing staff, residents, or other witnesses to the incident.	F0600		

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F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure an environment free of accident hazards for two of two sampled residents (29 and 43) who used electronic lift chairs in their rooms and were not assessed to determine the residents' ability to safely use those chairs independently, to mitigate the risk of accidents. Findings include: 1. Observation and interview on 7/26/2026 at 2:50 p.m. with resident 29 in his room revealed he was seated in an electronic lift chair with his feet elevated on the footrest, and the remote for the chair was draped over the armrest, within his reach. When the resident was asked if he knew how to use the remote to raise or lower his feet, he stated he did not know what the chair remote was for or how to use it. 2. Review of resident 29's electronic medical record (EMR) revealed he admitted to the facility on 11/7/25. He had diagnoses of Alzheimer's (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), dementia (a group of symptoms affecting memory, thinking, and social abilities), and anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). Resident 29 fell at home and fractured his right arm and hip before he admitted to the facility in December 2025, and sustained a left hip fracture that was surgically replaced on 12/31/25. Resident 29's EMR did not include any documented	F0689	Director of Nursing or Administrator will complete Root Cause Analysis. Director of Nursing and Administrator will review and revise policy on Accidents Prevention Policy as necessary. Director of Nursing or designee will educate all nurses on policy on assessments on Accident Prevention. Director of Nursing or designee will audit Resident 29 and 43 for safety on recliner repositioning. Director or Nursing or designee will ensure all other residents have recliner safety assessment completed and will be assessed quarterly with MDS audit will be completed, showing all residents have been assessed, monthly x three months report to QAPI for further review and consideration.	09/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435132	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA BRULE NURSING HOME INC	408 SOUTH JOHNSTON STREET , WHITE LAKE, South Dakota, 57383

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F0689 SS = D	Continued from page 11 assessment of his functional status, cognitive ability, strength, balance, judgment, or safety awareness related to his ability to independently use the electronic lift chair. No documentation indicated that he was evaluated for supervision needs, assistance needs, or environmental safety measures associated with his use of that chair. Resident 29's 5/20/26 Brief Interview for Mental Status (BIMS) assessment score was 4, which indicated his cognition was severely impaired. His current undated care plan indicated his cognition was severely impaired. His current undated care plan indicated that he was to transfer with substantial/maximum assistance from staff, and he was at risk for falls due to his impaired cognition and mobility. His care plan intervention initiated on 2/23/26 indicated that the staff were to encourage him not to elevate his footrest while he was in the electronic lift chair, and that the staff were educated about that intervention. 3. Observation and interview on 7/26/2026 at 1:10 p.m. with resident 43 in her room revealed she was seated in an electronic lift chair with her feet elevated on the footrest, and the remote for the chair was draped over the chair's armrest, within her reach. Resident 43 denied knowing how to use the chair's remote or what the remote was for. 4. Observation on 7/27/2026 at 11:44 a.m. and on 7/28/26 at 1:50 p.m. revealed resident 43 was seated in her electronic lift chair with her feet elevated on the footrest, with the chair's remote draped over the armrest, within reach of the resident. 5. Observation and interview on 7/27/2026 at 5:10 p.m. with certified nursing aide (CNA) N and resident 43 in her room revealed CNA N asked resident 43 in her room revealed CNA N asked resident 43 if she could use her chair remote to lower her feet in the electronic lift chair, and if she knew what the remote was for. Resident 43 stated, "It's for a whole lot of nothing." The CNA stated that staff knew which residents could have their feet raised on the footrest while sitting in the electronic recliner. 6. Review of resident 43's EMR revealed she admitted to the facility on 3/23/26. She had diagnoses of anxiety and rheumatoid arthritis	F0689		

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F0689 SS = D	Continued from page 12 (inflammation of the joints). Resident 43 fell and fractured her right hip on 3/17/26 before she admitted to the facility. Resident 43's EMR did not include any documented assessment of her functional status, cognitive ability, strength, balance, judgment, or safety awareness related to her ability to independently use the electronic lift chair. No documentation indicated that she was evaluated for supervision needs, assistance needs, or environmental safety measures associated with her use of that chair. Her 6/24/26 BIMS assessment score was 4, which indicated her cognition was severely impaired. Her current undated care plan indicated that she had an activities of daily living (ADL) self-care performance deficit related to her impaired balance, limited mobility, and musculoskeletal impairment due to her right hip fracture. Her 3/25/26 initiated care plan intervention indicated she required partial to moderate assistance from staff to stand and pivot to her wheelchair and needed to use a sit-to-stand mechanical lift (a medical safety device used to safely move people who cannot stand or walk on their own) for toileting. 7. Interview on 7/26/2026 at 3:02 p.m. with contracted travel CNA T revealed she utilized the resident's care plans in Point Click Care (PCC) (an electronic medical records system) to determine how to care for the residents. She indicated that she was trained on how to care for each resident by the facility staff upon hire. 8. Interview on 7/28/26 at 3:25 p.m. with administrator A revealed the staff did not assess residents for safety concerns when using a recliner, whether manual or electric. 9. Interview on 07/29/2026 1:15 PM with director of nursing (DON) B revealed staff were aware of which residents could use the electronic lift chair remote and if their feet should be elevated when they were sitting in those chairs. She indicated that the chair's remote should be left in the chair's side pocket if the resident did not know how to use it. 10. Review of the provider's reviewed 2/24/26 Resident Accident Prevention policy and procedures revealed "It is the policy of Aurora Brule Care and	F0689		

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F0689 SS = D	Continued from page 13 Rehab to ensure that the resident's environment remains as free as possible of accident hazards and that each resident receives adequate supervision and assistive devices to prevent accidents." "An accident is an unexpected, unintended event that can cause bodily injury. It does not include adverse outcomes associated as a direct consequence of treatment or care." "Accident hazards include, but are not limited to, physical restraints, poorly maintained resident equipment, bathing facilities lacking non-slip surfaces, hazards such as electrical appliances with frayed wires, cleaning supplies easily accessible to cognitively impaired residents, wet floors that are not obviously labeled and to which access is not blocked, handrails not securely fixed to the wall, and water temperatures that can scald or harm residents. Purpose: to provide a safe and accident-free environment. Procedure: The facility is continuously monitored by all staff for unsafe/hazardous conditions, and corrections are promptly made as needed to maintain a safe environment for residents. Resident equipment is inspected regularly to ensure proper and safe working conditions. All residents are assessed quarterly for their risk of accidents and falls, and receive individualized care planning related to their individual needs"	F0689		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F0761	Director of Nursing will complete Root Cause Analysis. Director of Nursing will review and revise as necessary labeling of medication policy. Director of Nursing or designee will educate all nursing staff and Med Aides on policy of labeling of medications. Director of Nursing or designee will audit 20% of resident's medication labels for accuracy weekly for four weeks, monthly for two months, and then quarterly for two quarters. Will report out to Qapi for further review and consideration.	09/09/2026

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F0761 SS = D	Continued from page 14 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure medications were labeled and administered according to the physician's orders for one of one (25) sampled resident who was administered lorazepam (an antianxiety medication) by one of one observed certified nursing assistant (CNA)/medication aide (MA) (M) from a medication blister pack (pre-formed plastic and foil packages that hold individual doses of pills or capsules in separate small pockets) with labeled administration instructions that did not match the physician's order for that medication in the resident's electronic medical record (EMR). Findings include: 1. Observation on 7/27/26 at 9:49 a.m. with certified nursing assistant (CNA)/medication aide (MA) M revealed that resident 25 received 0.5 milligrams (mg) of lorazepam along with other scheduled medications. CNA/MA M looked at the resident's physician order for lorazepam in her EMR and compared it to the resident's lorazepam medication blister pack card pharmacy label. She identified that the medication card's pharmacy label and the EMR had two different instructions for how often the medication was to be administered. Resident 25's lorazepam 0.5 mg EMR instructions indicated to "give 1 tablet by mouth four times daily" for anxiety disorder. The resident's lorazepam 0.5 mg medication card pharmacy label instructed to "give one tablet by mouth two times daily." CNA/MA M stated, "That is weird" and administered one 0.5mg lorazepam tablet to resident 25. 2. Review of resident 25's EMR revealed that she admitted to the facility on 4/22/26. She had orders for hospice services on 6/26/26. Resident 25 was started on 0.5mg lorazepam medication on 4/23/26, with the physician's order	F0761		

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F0761 SS = D	Continued from page 15 instructions to "give one tablet by mouth two times daily." The physician's order was changed on 6/28/26, with the instructions to "give one tablet by mouth three times daily." The lorazepam medication was changed by her provider again on 7/9/26, with the instructions to "give one tablet by mouth four times daily." 3. Interview on 7/27/26 at 4:11 p.m. with registered nurse (RN) Q revealed that if an order for a controlled (a drug that the government regulates because it can be misused, cause physical or psychological dependence, or lead to an overdose) medication like lorazepam was changed, two nurses were expected to destroy the tablets in that medication's blister pack card and then order a new card from the pharmacy with the updated instructions. 4. Observation and interview on 7/28/26 at 3:23 p.m. of the medication cart from resident 25's hallway with director of nursing (DON) B revealed that resident 25 had three medication cards of 0.5 mg lorazepam tablets. All three of those medication cards were labeled with the instructions to "give one tablet by mouth two times daily." DON B stated that two nurses were to destroy the medications if the medication order was discontinued. If the medication administration instructions changed, she expected staff to add a sticker on the medication card to indicate that those instructions had changed. The staff would then order a new medication card when medication supply in the card with the previous instructions ran out. She stated that resident 25's three medication cards should have had two stickers on the prescription label, one for when it changed from twice daily to three times daily, and another for when it changed from three times daily to four times daily. She would have expected staff to apply those stickers. 5. Review of the provider's 4/20/26 General Medication Administration policy and procedure revealed that during the medication pass, the staff was expected to check "if there is a discrepancy between the card, label, and MAR, hold the medication until the medication pass is completed and verify with the physician's order."	F0761		

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F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure that the staff followed standard safe food service practices regarding handwashing and glove use when handling ready-to-eat (RTE) foods by one of one dietary aide (L) during one of two meals observed. Findings include: 1. Observation during lunch on 7/28/26 from 11:52 a.m. to 12:12 p.m. in the kitchen revealed that the menu was chicken parmesan with noodles, lettuce salad, peaches in yogurt, and a slice of buttered bread. Dietary aide L was responsible for dishing the lettuce salad onto the plates, placing a plastic cup of salad dressing on the plates, and delivering the resident's meals using a pushcart. He used his right hand to scoop the lettuce salad onto the plates with a serving spoon, and he used his bare left hand to touch the salad so it would stay on the plate. He placed the plastic cups of salad dressing directly on top of the food on the plates, rather than on the side of the plate. He went back and forth from the kitchen to the dining room delivering the resident's meals at least five times and did not perform hand hygiene or	F0812	Root cause analysis completed, dietary aide L educated on safe food handling policy on 8/4/2026. Safe Food Handling Policy was reviewed by CDM. Rest of dietary staff were educated on safe food handling policy, hand hygiene, and glove use. Dietary Manager or designee will be auditing hand hygiene, proper glove use and safe food handling. Audits will be completed 3 times weekly at random shift times for four weeks and then 4 times monthly for two months. Dietary Manager will present findings to QAPI for further review and consideration.	9/9/2026

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F0812 SS = D	Continued from page 17 put gloves on his hands during the above observations. 2. Interview on 7/28/26 at 12:12 p.m. with dietary aide L about the above observations revealed he confirmed he touched the lettuce salad with his bare hands and did not perform hand hygiene or put gloves on before touching the lettuce salad with his hands. 3. Interview on 7/28/26 at 2:46 p.m. with certified dietary manager E revealed that he expected the staff to not touch RTE foods with their bare hands. He expected the staff to use serving utensils or perform hand hygiene and put gloves on when touching RTE foods. He did not realize the potential food contamination that could occur by placing the salad dressing cups directly on top of food. He expected the staff to perform hand hygiene each time they entered and exited the kitchen. 4. Review of the provider's 4/8/26 Food Preparation and Handling Policy revealed that "foods are prepared and served with clean tongs, scoops, forks, spoons, spatulas, knives, plastic gloves, or other suitable implements to minimize handling and to avoid manual contact of food at all points during preparation and service." 5. Review of the provider's 4/8/26 Glove Use in Dietary policy revealed that the employees will "wear gloves when handling any ready to eat foods like salad bar items, produce, sandwiches, cooked foods, deli meats, cheeses, breads, and ice."	F0812		
F0582 SS = B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F0582	Director of Nursing and Social Services will complete Root Cause Analysis. Director of Nursing or Social Services will review and revise policy on Medicare Beneficiary Notices. Director of Nursing or Social services will provide education to the MDS Coordinator on policy for Medicare Beneficiary Notices. Director of Nursing or designee will audit all Medicare Beneficiary Notices weekly for four weeks and monthly for two months and report to QAPI for further review and consideration.	9/9/2026

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F0582 SS = B	Continued from page 18 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider failed to ensure the required Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) Centers for Medicare and Medicaid Services (CMS) Part A form (CMS-10055) was provided for two of three sampled residents (26 and 43) reviewed for notification of Medicare benefits ending or their representatives to inform residents of potential financial liability for non-covered Skilled Nursing Facility (SNF) Part A services. Findings included:	F0582		

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F0582 SS = B	Continued from page 19 1. Review of resident 26's electronic medical record (EMR) revealed that resident 26's Medicare Part A Skilled Services Episode start date was 5/6/26. Resident 26's last covered day of Part A was 7/23/26. The facility provided residents 26 and 43 the CMS-R-131 form, which is not the correct notice for SNF non-coverage. The CMS-R-131 form in the in resident 26's EMR was not signed by the resident or the resident's representative; instead, a phone consent was given on 7/20/26. There was no documentation indicating the correct SNF Advance Beneficiary Notice of Non-coverage (ABN) CMS-10055 form was explained, issued, or given to resident 26 or the resident's representative. 2. Review of resident 43's EMR revealed that resident 43's Medicare Part A Skilled Services Episode start date was 12/16/25. Resident 43's last covered day of Part A was 1/7/26. The facility provided the CMS-R-131 form, which is not the correct notice for SNF non-coverage. The CMS-R-131 form in the EMR was signed by the resident on 1/5/26. There was no documentation indicating the correct SNF ABN CMS-10055 form was explained, issued, or given to resident 43 or their representative. 3. Interview on 07/28/2026 at 9:50 a.m. with Administrator A confirmed the CMS-R-131 form was used instead of the CMS-10055 form and acknowledged they did not have a signed CMS-10055 for resident 26 or resident 43.	F0582		
F0847 SS = B	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of	F0847	Business Manager will complete Root Cause Analysis. BOM will review arbitration policy and make revisions if necessary. BOM will review arbitration agreement and make necessary revisions, so it coincides with the arbitration policy. BOM will provide education to Department Managers other than herself if that may be responsible for explaining arbitration agreement to residents and/or their representative. BOM will provide education on the revised arbitration agreement to Resident 25 and their representative.	9/9//2026

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AURORA BRULE NURSING HOME INC	408 SOUTH JOHNSTON STREET , WHITE LAKE, South Dakota, 57383

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F0847 SS = B	Continued from page 20 admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, resident admission packet review, and policy review, the provider failed to ensure the binding arbitration agreement forms provided to residents or their representatives for review and signature contained the required information for one of one sampled resident (25). Findings include: 1. Interview on 7/27/26 at 12:32 p.m. with business	F0847	Social Services will audit new residents and or their representatives monthly for three months to determine if they were given choice to voluntarily enter into an arbitration agreement and make sure they were education and could understand what the agreement entailed then report to QAPI for further review and consideration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435132	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA BRULE NURSING HOME INC	408 SOUTH JOHNSTON STREET , WHITE LAKE, South Dakota, 57383

(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) COMPLETION DATE
F0847 SS = B	Continued from page 21 manager W revealed that she was assigned to develop and implement a binding arbitration agreement policy for the facility in January 2026. The policy was approved in March 2026, and only one resident's representative had signed an arbitration agreement form since then. Resident 25's representative signed the resident's arbitration agreement form. 2. Review of resident 25's signed binding arbitration agreement form revealed that it was signed by the resident's representative on 4/22/26. The agreement form did not include the following required items: that the resident or their representative have the right to rescind the agreement within 30 calendar days of signing the form; that the resident or their representative is not required to sign the agreement as a condition of admission to the facility or as a requirement to continue to receive care at the facility. 3. Phone interview on 7/29/26 with resident 25's legal representative revealed that she understood the agreement in terms of she would try to work out disagreements or grievances with the provider rather than "going over their head," such as submitting concerns to the state survey agency. She could not remember if the provider informed her that she was exempt from litigation by signing the agreement. She further explained that the provider might have explained that to her, but she could not remember that part explicitly. 4. Interview on 7/29/26 at 12:57 p.m. with administrator A revealed that business manager W was responsible for the binding arbitration agreement process at the facility. However, she was unavailable that day to discuss the agreements process. 5. Continued interview on 7/29/26 at 1:30 p.m. with administrator A revealed that she acknowledged that the facility's arbitration form that the residents or their representatives signed did not include some of the required information. She explained that their policy contained that information, but the form that was given to residents or their representatives did not. 6. Review of the provider's current admission packet revealed that a blank "Arbitration Agreement" form was included, but the policy that contained the required information was not included in that packet. 7. Review of the provider's 3/18/26 Voluntary Binding Arbitration Agreement Policy revealed that it	F0847		

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F0847 SS = B	Continued from page 22 was the facility's policy to "not require any resident or his/her representative to sign the VBAA [voluntary binding arbitration agreement] as a condition of admission to, or as a requirement to continue to receive care at the facility;" "provide the resident or his/her representative with a 30-day rescission period."	F0847		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435132	A. BUILDING B. WING	07/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 7/27/26. Aurora Brule Nursing Home Inc. was found in compliance.	E0000		

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 reverse for further 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
Kathleen Styles	Administrator	8/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435132	A. BUILDING **01 - MAIN BUILD...** B. WING	**07/27/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA BRULE NURSING HOME INC	**408 SOUTH JOHNSTON STREET , WHITE LAKE, South Dakota, 57383**

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 7/27/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Aurora Brule Nursing Home Inc was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000	The plan of correction prepared for this deficiency was executed solely because it is required by provision s of state and federal law. Without waiving the foregoing statement, the facility states that with respect to.	
K0712 SS = D Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to ensure the staff were familiar with the provider's fire drill procedures. Findings include: 1. Observation on 7/27/26 at 2:17 p.m. revealed a drill for a simulated fire in room 111 was being conducted. Further observation at that same time revealed the certified nursing assistant (CNA) responding needed prompting to initiate the response to the simulated fire. The maintenance technician running the fire drill had to walk the responding CNA through each of the R.A.C.E.	K0712	Maintenance Director will complete root cause analysis. Maintenance Director will review and revise as necessary the fire drill policy and procedures. Maintenance Director or designees will provide education on any changes or updates to procedure for fire emergency to all staff. Maintenance Director will provide education upon hire for all new staff on fire drill procedure. Maintenance director or designee will audit all current staff education weekly for four weeks then monthly for two months. Maintenance director or designee will report audit findings at the monthly QAPI meetings for further review and consideration.	09/09/2026

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 reverse for further 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
Kathleen Styles	Administrator	8/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 07/27/2026

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K0712 SS = D Bldg. 01	Continued from page 1 (Rescue, Alarm, Confine/Contain, and Evacuate) steps prior to the CNA taking any action. That CNA had to be further prompted by the maintenance technician as to where a manual fire alarm pull station was, as well as how and what to page on the building's public announcement system. Throughout this observation, the door to room 111 was never closed to confine the effects of the simulated fire. Interview with the maintenance manager immediately after the fire drill confirmed the findings that the CNA responding was not familiar with the provider's fire drill procedures. He believed they did not pass the drill. The deficiency had the potential to affect 100% of the building occupants	K0712		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10709	A. BUILDING: _____ B. WING _____	07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA BRULE NURSING HOME INC	408 S JOHNSTON ST WHITE LAKE, SD 57383

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/26/26 through 7/29/26. Aurora Brule Nursing Home Inc was found not in compliance with the following requirement: S121 and S206.	S 000	The plan of correction prepared for this deficiency was executed solely because it is required by provision s of state and federal law. Without waiving the foregoing statement, the facility states that with respect to.	
S 121	44:73:02:01 Sanitation The facility must be designed, constructed, maintained, and operated to minimize the sources and transmission of infectious diseases to residents, patients, personnel, visitors, and the community at large. This requirement shall be accomplished by providing the physical resources, personnel, and technical expertise necessary to ensure good public health practices for institutional sanitation. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to ensure the facility's air handling system was maintained in a manner to ensure good public health practices and institutional sanitation. 1. Observation and interview on 7/27/26 at 11:52 a.m. with maintenance manager X revealed eight of the building's corridor HV/AC (Heating, Ventilation, and Air Conditioning) diffuser grates had a moldlike substance found on the center of them. Of those eight diffuser grates, several of them were also rusty. Building HV/AC systems have the potential to spread pathogens if not properly cleaned or maintained. Interview with maintenance manager X at that same time revealed those diffuser grates were	S 121	The eight diffuser grates identified during this survey were removed, cleaned, painted, or replaced. Maintenance Director will review and revise the preventative policy to advise the HVAC grates are kept clean and in operational order. All other diffuser grates were assessed to ensure they were clean and in operational order. If found to be dirty or rusty, then they were removed, cleaned, painted, or replaced. Maintenance director will audit HVAC diffuser grates once quarterly for one year to ensure they are clean and in operational order. Maintenance Director will report audit findings at the monthly QAPI meetings for further review and consideration.	9/9/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathleen Styles — TITLE: Administrator — (X6) DATE: 8/25/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10709	A. BUILDING: _____ B. WING _____	07/29/2026

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S 121	Continued From page 1 previously identified as needing additional attention. He believed the issue was created by the water that continually condensed on them during the humid summer months.	S 121		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs. This Administrative Rule of South Dakota is not	S 206	Business manager will complete root cause analysis. Business manager or designee will review and revise policy on required education as necessary. Business manager or designee will provide education to all department managers responsible for education policy changes. Business manager or designee will audit all current staff education for completion. Business manager or designee will audit all new hired staff orientation monthly for two months then quarterly x2 and report to QAPI for further review and consideration.	8/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10709	A. BUILDING: _____ B. WING _____	07/29/2026

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S 206	Continued From page 2 met as evidenced by: Based on personnel file review and interview, the provider failed to ensure that one of two newly hired employees reviewed (O) completed the required orientation training topics within 30 days of hire. Findings include: 1. Review of employee O's personnel file revealed she was hired on 2/17/26. She did not complete the following training topics within 30 days of hire: infection control and prevention, proper use of restraints, resident rights, confidentiality of resident information, incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms, care of residents with unique needs, abuse and neglect, and advanced directives. 2. Interview on 7/29/26 at 11:03 a.m. with certified dietary manager (CDM) E revealed that employee O was a dietary aide in the dietary department. He completed the initial foodservice-related orientation and the required dietary training topics with employee O. Business manager W completed the rest of the training. 3. Business manager W was not available during the survey on 7/29/26 for interview. 4. Interview on 7/29/26 at 12:10 p.m. with administrator A revealed that she did not know why employee O did not finish her initial orientation training. She thought that it "just got lost in the chaos."	S 206		