STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435009	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MILBANK	1103 SOUTH SECOND STREET , MILBANK, South Dakota, 57252

(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 complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/5/26 through 5/7/26. Areas surveyed included a resident who was outside unattended; two residents who had an elopement; a resident who was not administered a physician ordered aspirin resulting in a deep vein thrombosis; a resident who allegedly did not receive a regularly scheduled bath, their call light was not answered promptly, and training of the staff; missing resident medications; a resident's care plan not followed resulting in a fall; a resident's care plan not followed for two staff members to provide cares which resulted in an allegation of the resident being verbally abused by a staff member, a resident's care plan regarding transfer from one surface to another not being followed, and a resident who sustained a chemical burn related to a staff member using a hair removal product on his intergluteal cleft (the crease between the buttocks). Avantara Milbank was found not in compliance with the following requirements: F550, F602, F609, F657, F658, F684, F689, F693, F740, F755, F760, and F761.	F0000		
F0740 SS = G	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review,	F0740	1. Resident #2 has been offered mental health services by social services and is agreeable at this time to receiving mental health services. All residents are at risk for deficient practice. All residents reviewed for need for mental health services. Mental health services offered to those residents in need or requesting mental health services by Social Services or designee by 6/6/2026. This will be ongoing with all new admissions, quarterly and with any change in mental health condition for all residents. 6/3/26 SC 2. The administrator, DON, and interdisciplinary team, in collaboration with the medical director, will review and revise the policy to ensure residents are provided behavioral/mental health care and services to treat diagnosed mental illness. The policy addresses processes to identify behavioral/mental health needs and interventions to meet those needs and continued/documented efforts to provide behavioral/mental health services for residents who refuse such services. Education will be provided to ALL staff on this policy, and that fosters understanding of behavioral/mental health, and their roles, responsibilities, interventions and appropriate responses to ensure the resident's overall emotional and mental well-being. Competencies of staff knowledge and implementation of all aspects of the education provided will be conducted and ongoing. Education will occur no later than 6/6/26. All staff not in attendance will be educated prior to their next working shift. 4. The Administrator or designee will audit all new admissions to be included in a sample of 5 residents weekly times four weeks and monthly times two months to ensure their mental health needs are being met. The results of these audits will be brought to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	06/06/2026

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
Sharon Martin	Administrator	6/3/2026

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F0740 SS = G	Continued from page 1 observation, interview, and policy review, the provider failed to ensure the staff followed the care planned interventions for one of one sampled resident (2) who expressed distress and reported allegations of abuse when one of one certified nursing assistant (CNA) (P) did not provide the resident's care with another staff member present, as identified in his care plan and the provider failed to provide necessary behavioral health care and services to support the resident's highest practicable mental, emotional, and psychosocial well-being. Findings include: 1. Review of the provider's 2/9/26 SD DOH FRI revealed that on 2/9/26, resident 2 posted a video on his Facebook page (social media site) that certified nursing assistant (CNA) P told him that if he called her a [curse word redacted] again, "that she was going to pull his hair and punch him in the face." In that video, resident 2 stated he felt it was his First Amendment right to speak to staff disrespectfully and call them a [curse word redacted] if he wants to. The facility's investigation could not determine if CNA P stated that she was going to pull his hair or punch him in the face. Resident 2 was to have two staff members present when his care was provided (cares in pairs) at all times. CNA P did not follow resident 2's care plan for providing cares in pairs, was "joking around with resident [2] during a conversation", and that resident 2 felt safe. 2. Review of resident 2's electronic medical record (EMR) revealed he was admitted to the facility on 10/10/25. His diagnoses included quadriplegia (a partial or total loss of function in all four limbs and the torso), anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and depression (a serious, common medical illness characterized by persistent sadness, loss of interest in activities, and low energy). His 4/19/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. Resident 2's 4/21/26 care plan included a 1/19/26 care plan intervention that indicated that resident 2 was to receive "Cares in pairs (care provided with two caregivers present)." The care plan had a 12/2/25 focus area that indicated that resident 2 was at risk for mood distress-signs and symptoms of anxiety (anticipation of future danger or misfortune	F0740		

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F0740 SS = G	Continued from page 2 with feelings of distress and/or sadness and symptoms such as restlessness or irritability). Interventions included encouraging him to reach out to the director of nursing (DON) or the assistant director of nursing (ADON), encouraging him to talk about “anything” that might be on his mind, evaluating the potential causal factors, and observing his psychosocial/emotional functioning. On 3/6/26, a focus area was added that indicated that he had a diagnosis of anxiety and depression, and that he had been offered and refused “therapy services.” A 4/25/26 focus area was added that indicated that resident 2 had a history of disruptive behaviors that interfered with his care and required additional staffing assistance, and that he posted “things” on Facebook and manipulated staff to do what he wanted. A 4/25/26 intervention was added that indicated to, “Allow [resident 2] to express feelings.” No other interventions were included for this focus area. There was no documentation in his EMR to support that resources such as cultural services, support groups for young adults with quadriplegia, mental health telehealth services, or religious services had been offered to resident 2 or that he had refused those services. 3. Observation and interview on 5/5/26 at 11:22 a.m. with resident 2, contacted travel certified nursing assistant (CNA) JJ, and CNA FF revealed that contracted travel CNA JJ and CNA FF assisted resident 2 to transfer from his wheelchair to his bed with the full body lift (a mechanical lift and sling used to lift a person’s full body). Resident 2 kept his eyes closed and did not talk to the staff members while they assisted him from his wheelchair to his bed with the full body lift. When the two CNAs left the room, resident 2 asked the surveyor to return later so that he could share his concerns. When asked why he did not talk to the staff members and kept his eyes closed, resident 2 stated that he was tired of arguing with the staff members. 4. Observation and interview on 5/5/26 at 1:40 p.m. with resident 2 in his room revealed he had been awake most of the night and morning and was having difficulty staying awake that afternoon. He stated he had several concerns he wanted to discuss, including his rights and how the staff members treated him. He was afraid to ask for	F0740	66666	

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F0740 SS = G	Continued from page 3 things because the facility had provided him a letter in January 2026 stating that they could not meet his needs and that they indicated they were going to make him leave when they found a facility that would accept him. He stated that the facility needed two staff members to provide his care because there had been multiple incidents when staff made “smart remarks” or he swore at them when he was frustrated or angry. He felt that staff made assumptions about him and the things he said, and “it led to problems”. He felt that having two staff members in the room helped him to feel safe most of the time, but not always. When he asked the staff members to leave his room, sometimes they argued with him, and he swore at them. He found it “ridiculous that they would argue with a quadriplegic person. Resident 2 did not feel like there was anyone that he could go to when he needed help resolving a problem. He did not feel like he could bring his concerns to social services designee (SSD) HH, because he was not allowed to talk to her. He was a tribal member and did not have a tribal case worker after he admitted to the facility, and he did not receive any therapy services. He felt that he could only get angry and yell if the staff did not listen to him. He thought that there was nothing else he could do because he was paralyzed, depended on the staff members for all of his needs, and he felt like no one was listening to him. He stated that SSD HH had filed for a restraining order against him. She accused him of “trashing” her office four days after he arrived at the facility. That restraining order had not been upheld in court, but she had little to no involvement in his care at the facility, after that. He was then told that he needed to take all of his concerns to administrator A. Resident 2 stated he was tired, ended the interview, and asked the surveyor to return the next day. 5. Interview on 5/6/26 at 9:54 a.m. with resident 2 in his room revealed he had concerns about staff members taking his personal items out of his room without his knowledge, he felt like “no one tells him anything,” and “He is sick of asking.” Resident 2 did not think he had spoken with the Ombudsman about his concerns and was unsure how that would have helped. He did not think that he received information about his resident rights and felt he would have been better informed if he had. Administrator A told him that he had to take all of his concerns to her.	F0740		

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F0740 SS = G	Continued from page 4 Resident 2 took all of his concerns to administrator A until a complaint regarding resident 2 and administrator A was filed, and now he wasn't able to talk to administrator A either. He had an Indian Health Services (IHS) caseworker before he was admitted to the facility, but did not remember her name. Resident 2 did not know if anyone had filled out a grievance form for him when he voiced his concerns. He was physically unable to fill them out himself. Resident 2 stated that when he discussed his concerns with staff members, including administrator A, they said they would follow up, but then they did not. Resident 2 felt like the rules were changing all the time and that the staff members he spoke to made up rules as they went. He stated he has stopped asking for help even when he needs it because he felt the staff did not want to help him, they argue with him, and they told him in January 2026 that he would have to leave the facility. He was unsure if the facility was still looking for another facility for him to go to. He felt that his opinions were not heard, and that he was tired of it and was "shutting down." He used to go out of his room more, but now he goes out to smoke and keeps his door closed. He stated that the staff members say they are joking around and sometimes say unkind things, but he felt "vulnerable" because he could not defend himself because of his medical condition, and he often yelled at or swore at the staff members. In February 2026, after he made a Facebook post about a staff member, DON B and CNA F came to his room to talk to him, and he felt very overwhelmed. He did not feel comfortable talking to DON B after that incident. He did not know who he could talk to about how he felt. 6. Multiple attempts were made on 5/6/26 and 5/7/26 to reach resident 2's resident representative by phone at the number listed in his EMR. These attempts were unsuccessful, and she was unable to be interviewed. 7. Interview on 5/6/26 at 2:25 p.m. with DON B regarding the letter resident 2 received in January 2026, revealed the facility had provided resident 2 a facility-initiated 30-day notice of discharge from the facility, that indicated they were unable to meet his needs and that he would be transferred to their	F0740		

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F0740 SS = G	Continued from page 5 sister facility. The sister facility reviewed his information and did not admit him. She was unsure if they were still looking for another facility to transfer him to. 8. Interview on 5/6/26 at 3:55 p.m. with SSD HH revealed that she had taken resident 2's vape out of his room about four days after he arrived at the facility because he was not allowed to have it until he was assessed by the nursing staff. Resident 2 became very upset and "trashed her office" by using his power wheelchair. She had filed for a restraining order against resident 2. That restraining order was not upheld in court, but she was told by administrator A not to have any contact with resident 2. SSD HH had been instructed by administrator A to only complete resident 2's social services paperwork, but administrator A talked to resident 2 and completed his social services assessments when they were due. SSD HH stated that "about two months ago," a complaint was filed against administrator A regarding resident 2. At that time, DON B was put in charge of resident 2's social services needs by administrator A. Within the past month, SSD HH became more involved in resident 2's care because "things were being missed," and SSD HH held resident 2's care conference in April 2026. Resident 2's representative attended his April 2026 care conference by phone and did not have any concerns. SSD HH stated that resident 2 did not talk or make eye contact during that care conference meeting. She stated that she offered resident 2 counseling services during that care conference and that resident 2 did not receive any mental health services because he had declined them. SSD HH stated that she had not been involved in issuing resident 2's facility-initiated 30-day notice of discharge from the facility, but thought that the facility was still looking for an alternative placement for him. She stated she felt uncomfortable around resident 2, and that administrator A was aware of this. 9. Phone interview on 5/7/26 at 10:26 a.m. with Indian Health Services Case Manager (IHS/CM) KK, revealed she assisted resident 2 and his family to find a long-term care (LTC) placement for him when he needed more assistance than he could receive in the community. She stated that her involvement with resident 2 ended when he admitted to the facility.	F0740		

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F0740 SS = G	Continued from page 6 Resident 2 knew he needed more care, accepted the need for LTC, and he agreed to come to the facility. She heard that once he got to the facility, things changed, and he was angry, but she was no longer involved in his care. She expected that there would be a period of adjustment as he transitioned to the facility. She thought that he might need mental health services or cultural services, but the facility had not reached out to her about any services that would be available to him through IHS, and she was unaware of the services that the facility was providing to resident 2. 10. Interview and review of resident 2's care plan and grievance forms on 5/7/26 at 3:44 p.m. with administrator A revealed that she was the grievance official and would complete the paperwork part of any grievance related to resident 2, but resident 2 was to bring all of his concerns to DON B. She stated that there had only been two grievances completed related to resident 2, and both were in regard to call lights. A complaint had been filed about and she was not allowed to be in a room alone with resident 2. SSD HH had limited interactions with resident 2 because she was uncomfortable around him. Administrator A stated she thought it was in resident 2's care plan that all of his concerns were to be brought to the ADON or the DON. She confirmed that at the time of the survey, there was no ADON working there. She expected that resident 2 would take all of his concerns to DON B and that DON B would complete a grievance form. Upon review of resident 2's care plan, administrator A confirmed that his 4/21/26 care plan indicated "Resident need[s] to bring all concerns to Administrator…" She stated this was inaccurate and needed to be updated. She was not aware that resident 2 did not feel comfortable talking to DON B. 11. Interview on 5/7/26 at 4:20 p.m. with administrator A and regional nurse consultant (RNC) LL regarding resident 2 revealed that administrator A thought that resident 2 did not participate in his admission paperwork process because he did not want to, and that he refused all offers of mental health and rehabilitation therapy services. Administrator A stated that resident 2 had never asked her for a copy of his resident rights or the facility rules. SSD HH was not allowed to be involved in resident 2's care, and she thought that	F0740		

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F0740 SS = G	Continued from page 7 SSD HH did not want to be involved. Administrator A put herself in charge of resident 2's social services needs until she was not allowed to be alone with him, and then administrator A had designated DON B to be responsible for his social service needs. When asked why the facility issued a 30-day notice of discharge to resident 2, administrator A stated it was because they could not meet his needs, and did not have people that he could talk to about his needs or concerns. When asked what social services were being provided to resident 2, administrator A stated that she did not know. 12. Interview on 5/7/26 at 6:27 p.m. with SSD HH revealed she offered resident 2 mental health services one time after he admitted to the facility, which included talk therapy with a counselor and telehealth psychiatry, and he declined. No tribal counseling services were offered. She did not think those services were available. She was then on leave from the facility for a period of time, and she was not sure if anyone else offered resident 2 mental health services during that time. SSD HH was unaware that a staff member threatened to punch resident 2. She thought that resident 2's care planned "cares in pairs" intervention was for the staff members protection. Resident 2 threatened that his family was going to come "shoot up the facility," then he wrecked her office. In October 2025, he attempted to elope, the police were called, and he went to the hospital, had a psychiatric evaluation completed, and was brought back to the facility. His physician was aware of his behaviors and managed them with psychiatric medications. SSD HH stated that resident 2's family told him he had to stay in long-term care (nursing home) because they could not take care of him. She thought he wanted to be at a facility where there were other Native Americans. The facility made referrals to other nursing homes, but none accepted him for admission to their facilities. When SSD HH or administrator A was no longer allowed to talk to resident 2, she was not sure who he talked with to meet his mental health needs. In March 2026, she started to take over some of resident 2's social service needs. She did not ask him for his approval but just went in to talk to him, and he talked to her now. She thought that she could visit with him without other staff members present. SSD HH completed resident 2's facility admission	F0740		

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F0740 SS = G	Continued from page 8 paperwork with his representative and was unsure if his representative gave him the copies. She did not give him a copy of his resident rights or the facility rules. 13. Review of the provider's 2/4/22 Social Services Designee's job description revealed "In keeping with our organization's goal of improving the lives of the Guests [residents] we serve, the Social Worker ensures that the medically related emotional and social needs of the Guests are met and maintained on an individual basis and in accordance with current federal, state, and local regulations." 14. Review of the provider's revised 5/14/25 Care Plans policy revealed "Care plans are accessible to all direct-care staff, including the resident's physician/provider. It is the responsibility of all direct care members to familiarize themselves with the care plans and review them routinely for changes." 15. Review of the provider's November 2020 Resident Rights booklet revealed "All nursing homes are required to provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care."	F0740		
F0760 SS = G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on a South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to ensure that residents were free of significant medication errors for one of one sampled resident (3) who admitted to the facility following a hospitalization for surgical repair of a fractured left hip and did not receive Aspirin 81 milligrams (mg) twice daily as ordered from the 12/19/25 p.m. dose through the 1/18/26 p.m. dose. Following that medication error, resident 3 experienced increased pain, spontaneous bruising, and increased swelling in her lower legs, which required medical	F0760	1. Resident #3 has discharged from the facility. Deficient practice was addressed by facility upon discovery of the medication variance. All residents are at risk for deficient practice. Facility discontinued the practice of pharmacy-initiated orders upon discovery of the variance. 2. All licensed nurses and medication aides will be educated on the medication error policy and complete competency by the DON or designee by 6/6/2026. Any staff who are not in attendance will be educated prior to their next working shift. 3. The DON or designee will review 5 random residents weekly times four weeks and monthly times two months to ensure that medications are being given as appropriate. The results of the audits will be brought to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	06/06/2026

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F0760 SS = G	Continued from page 9 intervention and developed Deep Vein Thrombosis (DVTs) (a blood clot that forms in a vein deep inside the body, most commonly in the lower leg or thigh) in both of her lower legs. Findings include: 1. Review of the provider's 1/7/26 SD DOH FRI revealed that during the consultant pharmacist (CP) medication regimen review on 1/2/26, the CP identified the pharmacy's order entry error regarding resident 3's 12//17/25 physician-ordered 81 mg Aspirin, twice daily, to continue for 30 days after her admission to the nursing facility following a left hip surgical repair. The nursing facility utilized a pharmacy-initiated order system in which pharmacy personnel received all physicians' medication orders and entered those medication orders into the nursing facility's order system, which included residents' electronic medical records (EMRs) and their electronic medication administration records (EMARs). The pharmacy received a clarification order on 12/19/25 to decrease the 81 mg Aspirin administration frequency from twice daily to once daily after 30 days. The pharmacy entered the physician's order for Aspirin 81 mg once daily, to start on 1/19/26, into the electronic pharmacy-initiated order system for resident 3. On that same day, the pharmacy entered an incorrect end date for the 81 mg Aspirin twice daily order, which caused a discontinued medication message to be sent in the facility's electronic medical record (EMR) system for resident 3. The pharmacy corrected that discontinued date error immediately on 12/19/25; however, the facility's order system was unable to update the discontinuation date, and as a result, the 81 mg Aspirin twice daily order never reappeared in the EMR as a corrected or continued order for administration to resident 3. Resident 3 last received her 81 mg Aspirin twice daily dose on 12/19/25 at 8:00 a.m. The order entry error resulted in resident 3 not receiving the scheduled Aspirin from the 12/19/25 p.m. dose through the 1/18/26 p.m. dose. She	F0760		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MILBANK	**1103 SOUTH SECOND STREET , MILBANK, South Dakota, 57252**

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F0760 SS = G	Continued from page 10 experienced increased pain, spontaneous bruising, and increased swelling in her lower legs, which required medical intervention, and developed DVTs in both of her lower legs. 2. Review of resident 3's EMR revealed that she admitted to the facility on 12/17/25 for therapy services after being hospitalized for surgical repair of her left hip fracture. While hospitalized, she developed a bowel obstruction (a blockage that prevents food, fluids, and gas from moving through the digestive tract) and required a second surgery on 12/6/25. Her diagnoses included hypertension (high blood pressure) and chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe). Her 12/23/25 Brief Interview for Mental Status (BIMS) assessment score was 12, which indicated she had moderate cognitive impairment. She discharged from the facility and returned home in the care of a family member on 1/16/26. Resident 3's progress notes dated from 12/21/25 through 12/30/25 indicated that she began complaining of increased swelling in her left lower leg on 12/21/25 at 9:04 p.m. On 12/24/25 at 10:53 a.m., a physical therapy (PT) progress note indicated that resident 3 complained of pain in both lower legs during her therapy session, which limited her activity, and she was unable to complete some of her exercises. Therapy staff documented that resident 3 had significant swelling in her bilateral lower extremities. The therapist did not document a pain level for resident 3 but assessed her pain based on her behaviors, including limited standing and walking, as well as difficulty lifting her feet off the floor. On 12/26/25 at 9:48 a.m., a PT progress note indicated that resident 3 had difficulty bearing weight on her legs due to increased weakness and pain in her lower left leg, and the therapy staff had to supervise all of her transfers. Resident 3 rated her pain 5/10 [five out of ten on a zero to ten level of pain scale] at rest and 7/10 [seven out of ten] with movement. She described her pain in the lower left leg at rest as an "ache" and with movement as	F0760		

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F0760 SS = G	Continued from page 11 "sharp". Progress notes on 12/26/25 at 12:04 p.m. and again at 6:00 p.m. indicated that resident 3 described pain in her left leg as "aching" and informed nursing staff that her right leg was "bothering" her, was purple in color, and that the purple bruising was not present earlier in the day. Resident 3 told nursing staff that she had not bumped or hit her leg on anything to cause purple bruising. Nursing staff documented that resident 3 had 3+ (moderate-to-severe) pitting (temporary "pit" or indenting left in the skin after applying pressure) edema (fluid-related swelling) in the right lower extremity (leg). A progress note dated 12/27/25 at 5:46 a.m. revealed that resident 3 verbalized left leg pain to nursing staff and that a dark bruise was noted on her right leg. At 3:00 p.m. that same day, resident 3 requested that her physician be notified about her pain and to order a stronger pain medication to help her with pain control. A physician's order was received to monitor her bruising to the back of her left lower leg every day and night shift until the bruising healed. A progress note dated 12/28/25 at 2:57 p.m. indicated that resident 3 experienced intermittent pain in her right leg. At 5:12 p.m., a PT progress note indicated that an ice pack was applied to resident 3's left lower leg during her therapy session to help reduce her pain and swelling. Resident 3 rated her pain a 3 on a zero-to-ten pain scale at rest and described it as "nagging and aching." A PT progress note dated 12/29/25 indicated that resident 3 attended a PT session. During the session, the physical therapist assistant/therapy coordinator (PTA/TC) U performed edema massage to resident 3's left lower leg to help reduce the tightness and swelling. Resident 3 arrived at that therapy session with a hematoma (a pool of clotted blood that forms outside of blood vessels, caused by injury or surgery) to her left medial (midline) gastrocnemius (two-part muscle located on the back of the lower leg that forms the calf muscle), with significant increased tenderness. There was no warmth or erythema (redness) to the area. Resident 3 had a positive Homans' sign (a clinical exam of flexing the foot upward toward the shin. If that	F0760		

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F0760 SS = G	Continued from page 12 movement causes pain in the calf muscle, that is considered positive and suggests a possible DVT) in her left lower leg. PTA/TC U notified former DON MM and recommended contacting the physician for an order to complete a Doppler exam (a non-invasive test that uses sound waves to assess blood flow through blood vessels). Resident 3 rated her pain at rest as 3 and at 9 with movement on a zero-to-ten pain scale. The resident described the pain as intense and sharp with movement. On 12/29/25 at 2:09 p.m., a progress note indicated that a fax was sent to notify the physician of resident 3's bruising on her right leg and to request a Doppler exam. Another progress note on 12/29/25 at 7:23 p.m. indicated that resident 3 was experiencing intermittent pain in her right leg. Progress notes from 12/29/25 through 12/31/25 indicated that on 12/29/25, a physician's order was received for resident 3 to undergo a Doppler exam, and the appointment was scheduled for 12/31/25. While attending therapy sessions during those dates, resident 3 continued to experience increased pain and swelling in her lower left leg, which limited her ability to stand, walk, maintain her balance, and perform bed mobility without difficulty. The Doppler exam was completed on 12/31/25 and revealed that resident 3 had bilateral DVTs in both of her lower legs. A physician's order was received for resident 3 to take 5 mg of Eliquis, a blood-thinning medication, orally twice daily for seven days, for her diagnosis of acute thrombosis (a sudden blockage of a blood vessel by a blood clot) in unspecified deep veins of the lower extremities. 3. A drug regimen review for resident 3 was completed by consultant pharmacist (CP) W on 1/2/26 and revealed that Aspirin 81 mg twice daily for resident 3 had not been administered since 12/19/26 at 8:00 a.m. and had not been continued as the physician ordered for 30 days. Her findings were documented in her report, and former DON MM was notified of the finding on 1/2/26. A medication variance report was completed five days later, on 1/7/26, by former DON MM regarding resident 3's omitted Aspirin 81 mg doses she did not receive from 12/19/25 through 1/18/26. 4. On 1/7/26, a corrective action plan was initiated, and the interdisciplinary team (IDT) met to review resident 3's bruising on her right lower leg and to	F0760		

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F0760 SS = G	Continued from page 13 complete an interview process with resident 3 and the nursing staff. The pharmacy addressed the order error entered by the pharmacy, which resulted in a medication error involving the aspirin for resident 3. A late-entry nurse progress note on 1/7/26 documented that the physician was notified that resident 3's Aspirin order to be given twice daily, was inadvertently discontinued by the pharmacy, the nursing facility's medical record system was unable to update the original discontinuation date sent on 12/19/25, and that the order for resident 3's Aspirin twice daily never reappeared as a corrected or continued order. A call was held on 1/9/26 with the pharmacy, facility leadership, and corporate leadership to discuss the root cause analysis, the error, how it occurred, and the process and plan for correction moving forward. On 1/12/26, a letter from the director of pharmacy was sent to the facility leadership outlining the education and training to be provided to the pharmacy staff. Training on 1/13/26 and 1/14/26 provided the pharmacy staff with education for those involved in the ordering error on 12/19/25, as well as a review of training documentation for all order-entry technicians and pharmacists. Updated material on discontinued orders and the impact on the facility was included in the training. In addition, on 1/14/26, three facility nurses involved in resident 3's Aspirin and order confirmation reviews completed training in a course titled "[Facility] LTC Pharmacy Initiated Orders". The pharmacy technology team attended an order entry meeting with the nursing facility's interface team (a specialized group that manages the software system) to review the process for discontinuing medication orders and future medication order start dates. The facility completed transitioning back to a facility-initiated order system rather than a pharmacy-initiated system on 1/28/26. 5. Interview on 5/5/26 at 2:06 p.m. and again at 3:30 p.m. with CP W revealed that pharmacy reviews were completed monthly with all residents. Resident medications and physician orders were reviewed. She would review progress notes and laboratory reports for changes to determine whether medications were contributing factors. She completed a comprehensive review of resident charts every month, and with any new resident admitted to the nursing facility.	F0760		

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F0760 SS = G	Continued from page 14 She indicated that the pharmacy has a team of nursing account managers who consult and provide education to nursing facilities. They can provide education as needed or upon request from the nursing facility. She acknowledged that a process improvement plan was implemented and completed regarding resident 3's pharmacy order error and that training was provided to the pharmacy team and to the nurses involved at the facility in January 2026. 6. Interview on 5/5/26 at 1:15 p.m. and again at 2:24 p.m. with the director of nursing (DON) B revealed that at the time the order entry error occurred with resident 3, the ordering system was pharmacy-initiated, and nurses were unable to enter physician orders into the facility's ordering system. However, she acknowledged that the facility nurses were responsible for confirming the orders that had been accurately entered by the pharmacy. She said that physician orders were sent to the pharmacy by e-fax or e-scribe at the time of resident 3's order-entry error, but that the facility now received the physician orders by e-fax, e-scribe, telephone, verbally, or in writing. 7. Interview on 5/6/26 at 10:21 a.m. with administrator A revealed that there were no medication errors related to order entries in the system since that incident. Nursing staff members now had the ability to put medication physician orders into the system. Administrator A acknowledged that when the error occurred regarding resident 3's medication, the pharmacy initiated the physician orders, the facility nurse confirmed the order, and an order error resulted in the discontinuation of her Aspirin, which was scheduled to be given twice daily. Administrator A said that she thought education on medication errors was provided to nurses regarding resident 3's ordering error. 8. On 5/6/26 at 11:44 a.m., interviews via phone call were attempted, and a voicemail message was left for resident 3 and resident 3's representative. No return calls were received during the survey. 9. Interview on 5/7/26 at 10:00 a.m. with PTA/TC U revealed that resident 3 admitted to the facility on 12/17/25 and had physician orders for physical and occupational therapy (OT). Resident 3 started PT on 12/17/25, started OT on 12/21/25, and experienced	F0760		

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F0760 SS = G	Continued from page 15 progressive pain, swelling, and bruising in her lower legs from admission until DVTs in both lower legs were discovered on 12/31/25. PTA/TC U stated that resident 3 continued her PT and OT therapy sessions five days a week, but at times, her pain and swelling limited her ability to stand, walk, and maintain her balance. She recalled the therapy session with resident 3, during which she identified a positive Homans' sign, notified former DON MM, and recommended that resident 3's physician be contacted to order a Doppler exam. She stated that she was happy with the timely response former DON MM provided by notifying the physician and obtaining an order for the Doppler exam for resident 3. PTA/TC felt that resident 3 not receiving the scheduled 81 mg of Aspirin twice daily could have been a contributing factor in the development of her bilateral lower leg DVTs. 10. Interview on 5/7/26 at 2:50 p.m. with RN/Minimum Data Set (MDS)coordinator J revealed that she received education regarding the incident involving resident 3's medication error. She reported that resident 3 had no further lower-leg pain or problems after starting Eliquis. 11. Interview on 5/7/26 at 5:30 p.m. with RN/Director of Electronic Health Records (EHR)/Point Click Care Implementation (PCCI) V stated that the facility transitioned to a facility-integrated system on 1/28/26 after a pharmacy order entry error involving resident 3 not receiving her medication as ordered was identified. That plan was adopted as the response to that incident. 12. Interview on 5/7/26 at 5:43 p.m. with administrator A, regional nurse consultant (RNC) M, and RN/vice president of clinical services (VPCS) X revealed that on 1/9/26 a call was held with the pharmacy team, the nursing facilities leadership team, and corporate office personnel to discuss the root cause of resident 3's medication error, how it occurred, and the processes and plan for correction to move forward. Administrator A and RN/VPCS X acknowledged that	F0760		

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F0760 SS = G	Continued from page 16 the ordering error resulted in resident 3 not receiving the scheduled Aspirin for approximately two weeks. Resident 3 experienced increased pain, spontaneous bruising, and increased swelling in her lower legs, which required medical intervention and developed DVTs in both of her lower legs. RNC M acknowledged that since the facility-integrated order system was implemented on 1/28/26, the facility did not conduct any audits to verify whether any further medication order entry errors had occurred for all residents, and that no data about that was presented at the monthly Quality Assurance and Process Improvement (QAPI) meetings. 13. Review of the provider's Medication Errors policy dated 5/14/25 revealed that the "Policy was to ensure medication errors are identified to prevent adverse resident effects. Errors will be documented, investigated, reported, and reviewed for the need of interventions and to prevent recurrence." "Medication errors will be reviewed by the Medical Director and Consultant Pharmacist. The review may be done via telephone, during routine visits, or during QAPI discussions." "The medication error will be entered into the Risk Management Section of [Facility System] for trending and tracking purposes." 14. Review of the provider's Following Physician Orders policy dated 11/18/25 revealed that the "Policy was to correctly and safely receive and transcribe the physician's orders so the correct order is followed/administered." "New admission/readmission physician orders and all transcription of orders should be transcribed by a HUC or a nurse and be double checked by a second nurse to ensure that all steps have been carried out to avoid errors."	F0760		
F0550 SS = E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F0550	See next page	

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F0550 SS = E	Continued from page 17 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, observation, interview, and policy review, the provider failed to protect the resident's rights for one of one sampled resident (2) who was not provided a copy of his resident rights, or could exercise his rights without interference, when staff members took away his personal possessions (his tattoo gun, his vape, and his computer), and failed to honor his requests for privacy and staff boundaries as documented in his care plan. Findings include: 1. Review of the provider's 2/9/26 SD DOH FRI revealed that on 2/9/26, resident 2 posted a video	F0550	1. Resident #2 has vape pen stored per smoking policy and is being assessed by therapy for safety of use of tattoo gun. Resident #2 has computer in his possession. All residents are at risk for deficient practice. All residents received a copy of their rights; rights were reviewed by 6/6/2026. 6/3/26 SC 2. All staff educated on resident rights and competency was completed regarding residents' rights by Administrator or designee by 6/6/2026. All staff who are not in attendance will be educated prior to their next working shift. 3. The administrator or designee will audit/interview a sample of five random residents to ensure their rights are being honored and needs are met weekly times four weeks and monthly times two months. The results of these audits will be brought to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	06/06/2026

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F0550 SS = E	Continued from page 18 on his Facebook page (social media site) that certified nursing assistant (CNA) P told him that if he called her a [curse word redacted] again, “that she was going to pull his hair and punch him in the face.” In that video, resident 2 stated he felt it was his First Amendment right to speak to staff disrespectfully and call them a [curse word redacted] if he wants to. The facility’s investigation could not determine if CNA P stated that she was going to pull his hair or punch him in the face. Resident 2 was to have two staff members present when his care was provided (cares in pairs) at all times. CNA P did not follow resident 2’s care plan for providing cares in pairs, was “joking around with resident [2] during a conversation”, and that resident 2 felt safe. 2. Review of resident 2’s electronic medical record (EMR) revealed he was admitted to the facility on 10/10/25. His diagnoses included quadriplegia (a partial or total loss of function in all four limbs and the torso), anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and depression. His 4/19/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. 3. Observation and interviews on 5/5/26 at 9:54 a.m., 11:22 a.m., and again at 1:40 p.m. with resident 2 in his room revealed that he wanted to know what his rights were. He stated that each time he got upset about something the facility had done, the staff members said it was because of “the rules.” He stated he had asked for a copy of “the rules” but was not provided with them. He stated he did not understand all the rules and that he would like to see the rules in writing. He asked administrator A and director of nursing (DON) B for a copy of the facility rules and policies, but they did not provide them to him. He was admitted to the facility in October 2025. Two family members were with him that day. He stated that he was not offered or provided a copy of his resident rights or the facility's rules when he was first admitted. He felt it was a violation of his rights that they took his vape and his tattoo gun out of his room while he was sleeping. He was allowed to use the vape now, but he did not know where his tattoo gun was located, and “no one will tell me.” He thought the tattoo gun was taken from his room in January 2026. He stated that two staff members were required to take care of him because he needed a significant	F0550		

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F0550 SS = E	Continued from page 19 amount of assistance with his care and because staff members were rude and disrespectful to him. He felt that having two staff members present during his care helped “most of the time, but not always.” He recalled the day, a couple of months ago, when he made a Facebook post about a staff member, and DON B and CNA F came to his room to talk to him. He did not want to listen to them and told them to “get the [curse word] out” of his room, but they would not leave. He was angry when DON B closed his computer and took it away. He said it made him angry because it was his personal property, and he could not take it back from her because he was paralyzed. He stated that DON B told him that he was not allowed to post about staff members on Facebook, because it was their right not to be recorded. He felt that it was his right to post on Facebook as long as he didn’t videotape the staff. He stated he wanted to know what his rights were. 4. Interview on 5/6/26 at 11:19 a.m. with CNA F revealed resident 2 was “very demanding” with the staff, frequently swore, and she always had another staff person with her when she provided his care. She did not recall DON B taking resident 2’s computer away from him, but resident 2 was told that he could not record the staff members in his room. When resident 2 requested the staff to leave his room, especially if he was upset, she was told to make sure he was safe and had his call light and then leave his room. 5. Multiple attempts were made on 5/6/26 and 5/7/26 to reach resident 2’s resident representative by phone at the number listed in his EMR. These attempts were unsuccessful, and she was unable to be interviewed. 6. Interview on 5/6/26 at 3:55 p.m. with social services designee (SSD) HH revealed she had assisted resident 2’s representative with completing the admission paperwork when resident 2 was admitted to the facility on 10/10/25. She confirmed that resident 2 was not present when she discussed the admission paperwork and the resident rights with his representative. She stated staff members were “getting him settled” in his room. His representative was not his power of attorney (POA) (someone designated on a legal document to act on behalf of a resident), but at the time of his admission, resident 2 was “not mobile,” and his representative signed all of his paperwork for him.	F0550		

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F0550 SS = E	Continued from page 20 SSD HH did not think that resident 2 had wanted to be part of that admission process. She did not recall if she had asked him, and she did not provide him with a copy of his resident rights. She had taken resident 2's vape out of his room about four days after he arrived at the facility because he was not allowed to have it. Resident 2 became very upset and "trashed her office" with his power wheelchair. Resident 2 was allowed to have the vape during smoking times after nursing completed the necessary assessments and obtained a physician's order for it. She was unaware that resident 2 had a tattoo gun and had very minimal contact with resident 2 after she took his vape away. 7. Interview on 5/7/26 at 2:45 p.m. with DON B revealed she became the DON in April 2026, and she did not know who had removed resident 2's tattoo gun from his room or that it was removed from his room while he was sleeping. She expected that the staff member who removed it from his room would have told him that it was unsafe for him to use, removed it from his room with his knowledge, and stored it in a safe place. She found the tattoo gun in her office cabinet on 5/6/26. The facility did not have a policy regarding his use of the tattoo gun, but she thought that an assessment for his safety would need to be completed. After resident 2 posted on Facebook about a staff member, administrator A told DON B and CNA F to inform resident 2 that he was not allowed to videotape the staff or the residents. She went into resident 2's room on 12/21/24. He was in bed, and his computer was on his bedside table in front of him. She closed his computer and moved it away from him. Resident 2 was upset and did not want to listen, but she told him that he needed to listen and that administrator A told her that she needed to have that conversation with him. She stated that he swore at her several times, and then he closed his eyes. Resident 2 asked DON B to leave his room, and she did not. She stated she left his room when she had finished talking to him. She confirmed that his care plan stated that the staff was to leave his room and reapproach him regarding his behaviors. She did not provide resident 2 with a copy of his resident rights, but stated the resident rights booklet was in the admission packet he received on admission, and that there were posters on the wall. She did not think resident 2 had requested a copy of his resident rights from her.	F0550		

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F0550 SS = E	Continued from page 21 8. Interview on 5/7/26 at 3:44 p.m. with administrator A revealed that resident 2's vape and tattoo gun were taken away from him for safety reasons. She was not aware that they were taken out of his room while he was asleep and expected that the staff would have explained why they were taken and where they would be stored. Resident 2 was allowed to use his vape during smoking times, but the provider did not have a policy about the use of his tattoo gun, and she was still looking into that. After resident 2 posted on Facebook about a staff member, administrator A told DON B to inform resident 2 that he was not allowed to videotape the staff or the residents. She was not aware that resident 2's computer was closed and moved out of his reach or that he became upset and requested that DON B leave his room. Administrator A expected all staff members to respect resident 2's wishes and leave his room when asked and reapproach him later, especially if he was upset. She was not aware that resident 2 wanted a copy of his resident rights and the facility rules, nor had she provided a copy of them to him. She thought that SSD HH would have provided that information when he was admitted to the facility. She was not aware that resident 2 did not participate in the admission process with SSD HH on the day of his admission. Resident 2 was to have all his care provided with two staff present for his safety and for the safety of the staff. 9. Review of the provider's November 2020 Resident Rights booklet revealed "All nursing homes are required to provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care." The right to be fully informed of "Facility rules and regulations, including a written copy of resident rights." "right to Dignity, Respect, and Freedom: Security of possessions." "The resident has the right to be free from interference, coercion, discrimination, and reprisal when exercising their rights as a resident in long term care and as a citizen of the United States."	F0550		
F0602 SS = E	Free from Misappropriatio /Exploitation CFR(s): 483.12 §483.12	F0602	See next page	

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F0602 SS = E	Continued from page 22 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. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incidents (FRIs), personnel files, record review, observation, interview, and policy review, the facility failed to protect the residents' property for one of one sampled resident (4) who had 13 Hydrocodone/APAP (acetaminophen) (a narcotic medication to treat moderate to severe pain) 5-325 milligram (mg) tablets go missing by one of one contracted travel registered nurse (RN) (N) and one of one sampled resident (5) who had one lorazepam (a medication to treat anxiety) 0.5 mg tablet found missing by licensed practical nurse (LPN) L and contracted travel LPN (T) and was not found. Findings include: 1. Review of the provider's 1/20/26 SD DOH FRI revealed that at approximately 8:30 a.m. on 1/20/26, contracted travel registered nurse (RN) N entered resident 4's room with his medication card, which contained his PRN (as needed) Hydrocodone/APAP 5-325 mg tablets, and the rest of his morning medications for administration to the resident. Approximately two hours later, RN N discovered she had misplaced the medication card of 13 tablets of Hydrocodone/APAP and reported that the medication card was missing to former director of nursing (DON) E between 12:45 p.m. and 1:00 p.m., and an investigation was started. Camera footage revealed that throughout the morning and early afternoon on 1/20/26, numerous staff members and resident 1 entered resident 4's room. Certified nursing assistant (CNA) P entered resident 4's room with his breakfast tray shortly after 8:30 a.m. and immediately exited the room. At 9:02 a.m., housekeeper K entered his room and exited at 9:08 a.m. Contracted travel CNA O entered his room at 9:09 a.m. to assist resident 4 in getting up and ready for the day, and she exited the room at 9:20 a.m. At 11:18 a.m., CNA Q entered resident 4's room and took him to lunch. At 12:03 p.m., resident	F0602	1. Resident #4 received new card of hydrocodone/ APAP medication. Resident #5 received a replacement dose of lorazepam. There were no adverse outcomes related to missing medication. All residents are at risk for deficient practice. A house wide audit was conducted of all narcotics in the facility and were accounted for. 2. All licensed nurses will be educated on Abuse and NeglectPolicy,which includes misappropriation by the DON or designee by 6/6/2026. All licensed nurses not in attendance will be educated prior to their next working shift. 3. The DON or designee will audit all narcotics in the facility to ensure counts are accurate and there are no missing medications weekly times four weeks and monthly times two months. The results of the audits will be brought to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	06/06/2026

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F0602 SS = E	Continued from page 23 4 and resident 1 entered resident 4's room together. At 12:12 p.m., contracted travel RN N entered resident 4's room and then exited, and at 12:18 p.m., resident 1 exited. At 12:23 p.m., resident 4 left his room and attended therapy. The final report noted that contracted travel RN N stated she had taken the medication card containing 13 tablets of resident 4's Hydrocodone/APAP to his room that morning to save time, as she was in a hurry and the resident often requested a tablet of that medication in the mornings. A count of all the residents' controlled medications was completed by regional nurse consultant (RNC) M and contracted travel RN N, and all counts were accurate except for resident 4's known missing Hydrocodone/APAP. The medication card containing resident 4's Hydrocodone/APAP 5-325 mg tablets was never located after thorough searches of the facility during the investigation. Review of the personnel files for contracted travel RN N and contracted travel CNA O revealed that both had completed orientation training and education through their employing agency and received additional training and education through the facility. There were no prior disciplinary actions in their files. Their education included topics such as misappropriation of resident property and drug diversion (illegal transfer or use of prescription drugs). Contracted travel RN N's last working shift at the facility was on 1/20/26, when she was suspended from working at the facility pending the investigation, and her work contract with the facility was terminated on 1/21/26. Contracted travel CNA O remained on the facility's schedule and was allowed to work. Her last shift at the facility was on 3/31/26. 2. Review of resident 4's electronic medical record (EMR) revealed that he had a seizure and fell in his home on 11/27/25, which resulted in compression fractures (bones in the mid-back have collapsed or become crushed, causing back pain) of his T4, T5, and T6 vertebrae (the 4th, 5th, and 6th bones) and his admission to the hospital. He admitted to the facility on 12/12/25 and received therapy services. His diagnoses included seizure disorder (a condition with recurring, unpredictable seizures), cardiac arrest (the heart suddenly stops beating, cutting off blood flow to the brain and other vital organs), and lower extremity weakness. His 3/24/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact.	F0602		

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F0602 SS = E	Continued from page 24 3. Interview on 5/6/26 at 4:50 p.m. with resident 4 in his room revealed that he recalled the incident that involved his missing Hydrocodone/APAP medication card in January 2026. Resident 4 said he gave staff permission to search his room for the missing medication card, and he was questioned by the police. Resident 4 denied keeping the card and taking the medication himself, stating that he never saw a medication card left in his room and was unsure whether the nurse had even brought the Hydrocodone/APAP medication card into his room that day. Resident 4 stated that he had been taking that medication to help control his pain from the compression fractures in his back. He remembered eating breakfast in his room that morning, and that a CNA brought him his meal tray and another CNA later assisted him to get ready for the day, but he could not recall their names. Resident 4 said the nurse brought him his medications, but he could not recall her name. He did not see the nurse or CNA with a medication card when either left his room. Resident 4 was not sure what had happened to the missing medication card, but the pharmacy replaced the medication for him. Resident 4 said he requested one of his PRN Hydrocodone/APAP medication tablets for his pain that morning and that it was administered to him by contracted travel RN N. He stated that his missing Hydrocodone/APAP tablets were never found. 4. Interview on 5/7/26 at 11:15 a.m. with housekeeper K regarding the missing medication card of Hydrocodone/APAP revealed that she recalled the incident involving resident 4's missing medication card of Hydrocodone/APAP. She cleaned resident 4's room the morning that the medication card went missing and thought she entered his room between 9:00 a.m. and 9:30 a.m. Housekeeper K did not see a medication card in his room or in the trash. She indicated that checking resident trash was a daily task on their list to complete, to look for residents' personal items that may have been thrown away unintentionally, such as glasses, hearing aids, and dentures. 5. On 5/7/26 at 12:08 p.m., a call was placed to CNA P, which was unanswered. A voicemail message was left requesting a return call. No return call was received during the survey.	F0602		

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F0602 SS = E	Continued from page 25 6. Interview on 5/7/26 at 12:23 p.m. with CNA Q revealed that she remembered contracted travel RN N looking for a missing medication card for resident 4 during a morning shift she worked. On the day that the resident's medication went missing, she entered resident 4's room just before lunch and assisted him to the dining room. She heard from other staff members that a medication card for resident 4 was left in his room by contracted travel RN N and was not found after the room was searched. Contracted travel RN N told CNA Q that she was asked to leave her shift and would be leaving the facility between 3:00 p.m. and 4:00 p.m. CNA Q was unsure whether resident 4's missing medication card was found. 7. A review of the educational material provided to the nursing staff regarding the 1/20/26 incident of resident 4's 13 missing Hydrocodone/APAP tablets revealed that the information was typed and titled "Education." No date was typed or written on the 1-page document. The education document provided to the nursing staff stated, "Do not take medication cards into resident rooms." "Do not leave meds at bedside." "If you notice any medications left in the room, notify the charge nurse or nursing administration immediately for removal." "Sign below:" 14 nurses signed that education document, but education was not provided to all nurses regarding the 1/20/26 incident of resident 4's missing medication card. 8. Review of the provider's 4/8/26 SD DOH FRI revealed that at approximately 6:00 a.m., during the shift change, licensed practical nurse (LPN) L and contracted travel LPN T were completing the routine change of shift controlled medication count of the controlled medications in one of the two facility's medication carts. During that count, it was discovered that one 0.5 mg lorazepam tablet was missing from resident 5's lorazepam morning dose medication card. The packaging on the back of that lorazepam medication card had a small hole, and no tablet was in it. On 4/8/26, the medication cart and surrounding areas were searched, but the missing 0.5 mg lorazepam tablet was not found. director of nursing (DON) B checked all other controlled medications and found no other discrepancies. It was discovered that the nurses were not fully removing the	F0602		

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F0602 SS = E	Continued from page 26 controlled medication cards from the narcotic (controlled pain medications) locked drawer to obtain a clear view of all the pills, and were not comparing the actual number of pills in each medication card with the controlled drug record forms to verify that those counts matched. The nursing staff was unsure how long resident 5's lorazepam tablet had been missing. The investigation concluded that resident 5's missing lorazepam 0.5 mg tablet was accidentally ejected from the medication card at some point, unnoticed, and potentially swept up by housekeeping staff. 9. Review of resident 5's EMR revealed that she admitted to the facility on 1/11/23. Her diagnoses included weakness, repeated falls, abnormal gait (any waling pattern that deviates from the usual walk), delusional disorder (false beliefs and distorted views of reality), bipolar disorder (a mental health condition that causes extreme shifts in mood, energy, and activity levels), anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and dementia (a group of symptoms affecting memory, thinking, and social abilities) with behavioral disturbance. Her 4/4/26 BIMS assessment score was 07, which indicated her cognition was severely impaired. 10. Interview on 5/5/26 at 10:47 a.m. with resident 5 revealed that she did not recall that one 0.5 mg lorazepam tablet was missing on 4/8/26 or if the nursing staff reported it to her. 11. Phone interview on 5/5/26 at 11:50 a.m. with resident 5's representative revealed that the facility contacted her and discussed any changes in resident 5's care. The staff would contact her by phone and let her know if any new medications were ordered or if medications were changed. She stated, "I talk to them all the time, and they are on top of it." She stated that she was probably notified of the missing 0.5 mg lorazepam tablet and had no concerns regarding that incident. 12. Interview on 5/6/26 at 4:35 p.m. with LPN L related to resident 5's missing 0.5 mg Lorazepam tablet revealed she could not recall that resident 5 was missing a 0.5 mg lorazepam tablet during the controlled medication count at shift change the morning of 4/8/26. She did not recall if she had completed a thorough search of the medication cart	F0602		

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F0602 SS = E	Continued from page 27 and the surrounding area to locate the missing medication, or if contracted travel LPN T had. She was not sure who had notified the nurse supervisor or the DON or whether the missing lorazepam tablet was found. 13. Interview on 5/7/26 at 11:50 a.m. with contracted travel LPN T revealed that she was the nurse going off duty the morning of 4/8/26. When she was completing the controlled medication count with LPN L, it was discovered that resident 5 was missing one 0.5 mg lorazepam tablet from her morning lorazepam dose medication card. She and LPN L searched the medication cart and the surrounding area but did not find the missing tablet. She stated, “I am not sure how long it was missing.” She said she did not report the missing medication to the nursing supervisor or the DON, but LPN L reported it to the unit manager, LPN I. She acknowledged that she received education to check both the controlled medication log and the medication card during the count to verify the accuracy of residents' controlled medications. 14. Review of the educational material provided to the nursing staff regarding resident 5’s missing lorazepam tablet on 4/8/26 revealed that the information was typed and titled “Attention Nurses:”. No date was typed or written on the 1-page document. The education document stated, “When counting narcotics during shift change, please be sure to pull the card all the way out, count the pills, and check the back of the card to ensure there are no tears or openings. It is also suggested that you look at the book and verify that the number that’s being read to you is correct. If the count is off/wrong, DO NOT LEAVE THE BUILDING. Contact former DON NN, administrator A, AND DON B. If for any reason you cannot get in touch with one of them, call LPN I, whose number is listed in the numbers binder at the nurse’s station. Narcotic audits will also be performed regularly moving forward.” An in-service sign-in sheet indicated that RN R, LPN I, and LPN L received that education on 4/17/26 after it was identified that resident 5’s lorazepam tablet was missing on 4/8/26. No other nurses at the facility received education. Weekly audits regarding accurate narcotic counts began on 4/10/26 following resident 5’s missing lorazepam tablet.	F0602		

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F0602 SS = E	Continued from page 28 15. Observation and interview on 5/5/26 at 1:30 p.m. with LPN I in the 200 hallway, of the controlled medications and the count sheets in cart one revealed that the medication cart contained controlled medication cards that were stored in a locked box in a locked drawer. Controlled medications were stored that way in all the facility's medication carts. LPN I stated that two nurses were to count the controlled medications at each shift change, which occurred twice daily or as needed based on staff schedules. She said that whenever possession of the keys changed, a count was completed. A controlled medication count for cart one was completed with LPN I and revealed that residents' controlled medication cards were stored in the locked narcotic box, and there were no medication count discrepancies. LPN I did not think that education was provided after resident 4's medication card of 13 tablets of Hydrocodone/APAP, was reported missing. 16. Interview on 5/5/26 at 2:06 p.m. and again at 3:30 p.m. with consultant pharmacist (CP) W revealed that pharmacy reviews were completed monthly for all residents. Resident medications and physician orders were reviewed, and gradual dose reduction (GDR) recommendations were provided to residents prescribed psychotropic medications (drugs that affect brain activities associated with mental processes and behavior). She would review progress notes, care plans, Minimum Data Set (MDS) assessments, and laboratory reports for changes to determine whether medications were contributing factors to residents' changes in condition. She completed a comprehensive review of resident charts every month, and for any new resident admitted to the facility. She stated that the pharmacy strongly encouraged facilities to report any missing medication to the pharmacy staff. 17. Observation and interview on 5/6/26 at 12:00 p.m. with contracted travel LPN S in the hall next to the nurse's station revealed that she had received education to check both the controlled medication log and the medication card during the count to verify the accuracy of residents' controlled medications. A controlled medication count for cart two was completed with contracted travel LPN S, and all controlled medications were securely stored in the locked box inside the locked cart with no	F0602		

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F0602 SS = E	Continued from page 29 medication count discrepancies. 18. Interview on 5/7/26 at 3:10 p.m. with DON B revealed that she expected nursing staff to be at their medication carts when “punching” medications out from the medication cards when preparing medications to administer to residents. Nurses were not to take medication cards into resident rooms. If a medication was missing, DON B expected nurses to search for it by checking cards stored around the missing medication to determine whether it was removed from the wrong medication card, checking whether it was signed out on the wrong narcotic drug sheet, checking the back of the medication card to see if it was stuck in the packaging, looking in the bottom of the medication cart drawer for it, and reviewing all narcotic drug sheets and medication administration records (MARs) for every entry. After the search, if the medication was not found, the nurses were to contact her as quickly as possible, and she would start an investigation. DON B stated that the physician and family were to be notified of missing medications, and residents were to be notified if they were responsible for themselves. She expected the information to be documented in a progress note. DON B stated that if medications were missing, the pharmacy needed to be replaced. DON B stated that she did not know what had happened to resident 4’s Hydrocodone/APAP tablets and that contracted travel RN N, taking his medication card down to his room to administer it, was suspicious of drug diversion, as the 13 Hydrocodone/APAP tablets were never found. She said that the facility's camera footage was reviewed on 1/20/26 and confirmed that contracted travel RN N entered resident 4’s room that morning with his Hydrocodone/APAP medication card in hand, but exited without it. Law enforcement was notified on 1/20/26 regarding the missing Hydrocodone/APAP tablets belonging to resident 4, and an officer came to the facility and interviewed him. Resident 4 refused to allow the facility nurse, whose name DON B could not recall, to search him for the missing medication card. DON B stated that she did not know what had happened to resident 5’s lorazepam tablet on	F0602		

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F0602 SS = E	Continued from page 30 4/8/26 and that she had checked all other controlled medications that morning and found no other discrepancies. DON B said that the nurses were not removing the controlled medication cards from the narcotic drawer to obtain a clear view of all the pills, and were not comparing the actual number of pills in each medication card with the controlled drug record forms to verify that those counts matched. She thought that resident 5's missing lorazepam tablet was accidentally ejected from the medication card, unnoticed, and swept up by the housekeeping staff. DON B said that all nursing staff were trained to remove the controlled medication cards from the medication carts, and both nurses were to verify that the medication card counts matched the counts on the controlled medication count sheets. She was not sure whether audits had been completed for the missing medications for residents 4 and 5, or whether incidents involving missing medications had been reported to the monthly QAPI meetings for tracking, recommendations, and process improvement plans. 19. Review of the provider's Quality Assurance and Process Improvement (QAPI) reports for 1/28/26, 3/25/26, and 4/21/26 revealed that medication variance reports were included as a section of the facility's QAPI document for review during the facility's monthly meetings. The incident investigation sections of the QAPI reports included one medication variance in the 1/28/26 report that occurred in December 2025. The 3/25/26 report had no medication variances from February 2026. The 4/21/26 report had one medication variance that occurred in March 2026. The "Corrections Section" for 1/28/26 and 3/25/26 indicated that "staff education" was provided and that the facility transitioned to a facility-initiated ordering system, which allowed the facility to enter physician orders, as planned after the order-entry error occurred with resident 3. No February 2026 QAPI report was provided during the survey for review to verify that resident 4's January 2026 medication variance was documented or to determine whether processes were in place to address his missing medication for tracking and trending, recommendations, and discussion.	F0602		

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F0602 SS = E	Continued from page 31 The medication errors section of the QAPI reports included one medication error in the 1/28/26 and 3/25/26 reports. No information was provided about the medication error in the 1/28/26 report. The 4/21/26 report indicated that “Missing Norco” (a brand name for Hydrocodone/APAP) was noted and that “nursing education” and “audits” were being completed “two times weekly” to ensure the accuracy of controlled medication counts. 20. Interview and record review on 5/7/26 at 5:43 p.m. with administrator A, regional nurse consultant (RNC) M (via phone), and RN/vice president of clinical services (VPCS) X revealed that DON B reported missing medication incidents to administrator A and, if determined to be reportable, administrator A completed a report to the SD DOH. Administrator A acknowledged that she reported the missing medications for residents 4 and 5 to the SD DOH. Administrator A stated that medication variances were reported at the monthly QAPI meetings. Administrator A expected that controlled medications be counted by the incoming and outgoing nurses at every shift change. After the controlled medications were counted, she expected both nurses to sign the narcotic drug sheet, which indicated that the controlled medication count was complete and accurate. If the count was inaccurate, a search for the medication was to be conducted, and DON B was to be notified immediately. *She acknowledged that staff not counting the controlled medications at every change of shift by the incoming and outgoing nurses could increase the risk of drug diversion and would make it difficult to determine when the controlled medication went missing. Administrator A, RN/VPCS X, and RNC M indicated that education was provided to all the nurses following the incidents involving resident 4 and resident 5’s missing medications, which included the nurses not to take medication cards into resident rooms and to pull medication cards from the medication cart drawer to view all the pills and compare the pill counts to the controlled medication count sheets. Missing medication audits were being conducted, and the results were being reported at QAPI meetings.	F0602		

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F0602 SS = E	Continued from page 32 Resident 4 and resident 5's education documents and audits related to their missing medications were discussed. Administrator A, RN/VPCS X, and RNC M acknowledged that not all nurses received education related to resident 4 and resident 5's missing medication incidents and that audits had not been initiated after resident 4's missing medication was identified. RNC M acknowledged that audits began on 4/10/26 following the missing lorazepam tablet for resident 5, but not all nurses were educated after that incident. Administrator A, RN/VPCS X, and RNC M acknowledged that routine audits to monitor medication passes and controlled medication counts had not been conducted, including verifying that two nurses counted together at every shift change, monitoring the medication count process between nurses, and reviewing the narcotic count sheets for accuracy and nurse signatures. They acknowledged that audits related to missing medications and medication errors had not been tracked and monitored effectively through the facility's QAPI process, and that the QAPI reports provided limited information about the process improvement plan for those identified areas. 21. Review of the provider's revised January 2018 Discrepancies, Loss and/or Diversion Of Medications policy revealed, "The DON investigates the discrepancy and researches all the records related to medication administration and the supply of the medication, including medication reconciliation." "A thorough search in all drug storage areas, the resident's room, and other locations where medications may have been use/placed during the medication administration are made to locate any missing container or medication supply." "Accountability of the medication in question should be checked several times in the following days to assure that accountability is being maintained." "The DON investigates the suspected loss and researches all the records related to medication receipt, its use since receipt, all persons involved with medication administration, and the supply of the medication." "The dispensing pharmacy should be notified, and the pharmacy should verify that the medication was actually dispensed." "If the loss involves a controlled substance, all the controlled drug accountability procedures and	F0602		

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F0602 SS = E	Continued from page 33 documentation should be reviewed and audited." "Appropriate agencies, required by state and federal law, will be notified." 22. Review of the provider's revised January 2018 Medication Storage In The Facility policy revealed, "At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed nurses and is documented." "Any discrepancy in controlled substance counts is reported to the director of nursing immediately." "The director or designee investigates and makes every reasonable effort to reconcile all reported discrepancies." "If a major discrepancy or a pattern of discrepancies occurs, the director of nursing notifies the administrator and consultant pharmacist immediately." 23. Review of the provider's revised January 2018 Consultant Pharmacist Services Provider Requirements policy revealed, "The consultant pharmacist provides consultation on all aspects of the provision of pharmacy services in the facility." "Assists in the identification and evaluation of medication-related issues, including the prevention and reporting of medication errors." "Establishes a system of records for receipt and disposition of all controlled medications to enable an accurate reconciliation, and to determine that the drug records are in order and that an account of all controlled medications is maintained and periodically reconciled." "Assists in establishing quality assurance and continuous quality improvement activities regarding the medication use process, prescribing, dispensing, storing, administering, and monitoring of medications in the facility." " Assists nursing in reviewing medication administration records, treatment administration records, and physician orders quarterly within the QAPI process to ensure proper documentation of medication orders and administration of medications to residents."	F0602		
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment	F0684	See next page	

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F0684 SS = E	Continued from page 34 of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, observation, and policy review, the provider failed to ensure: residents received quality care when one of one certified nursing assistant (CNA) H applied Nair (chemical hair removal cream) cream to one of one sampled resident's (2) anal area and inner buttocks who did not have a physician's order for the use of that cream and subsequently sustained a chemical skin burn; and ensure call lights were answered timely for four of six sampled residents (1, 6, 11, and 13) who reported having to wait a long time for the staff to answer their call lights. Findings include: 1. Review of the provider's 4/24/26 SD DOH FRI revealed that on 4/23/26, CNA H applied Nair cream to resident 2's anal area and inner buttocks when she gave the resident his shower. On 4/22/26, administrator A has told resident 2 that Nair cream was "not recommended for use on sensitive skin areas." Administrator A was unaware that resident 2 purchased the Nair Cream online. "Despite the education provided, the resident insisted on its use." The provider determined that CNA H applied the Nair cream to resident 2's anal area and inner buttocks "outside of her scope of practice and she should have first consulted with a licensed nurse." Resident 2 denied pain or discomfort. "Nurse was notified after the shower." A barrier cream "containing zinc and dimethicone was initiated to protect the affected skin." A nursing order was entered into the treatment administration record (TAR) on 4/23/26 to apply barrier cream twice daily to resident 2's buttocks. A skin evaluation was completed by licensed practical nurse (LPN) I on 4/29/26. No new skin alterations were noted to the areas. 2. Review of resident 2's electronic medical record (EMR) revealed he was admitted to the facility on 10/10/25. His diagnoses included quadriplegia (a partial or total loss of function in all four limbs and the torso). His 4/19/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. He had a 4/23/26	F0684	1. Resident #2 does not have medication at bedside. For residents 1, 6, 11, and 13 call lights are being answered timely. All residents are at risk for deficient practice. A house wide sweep was conducted to ensure no medications or creams are at beside that require a provider order without proper documentation to support bedside use. 2. All nursing staff will be educated on proper storage of medications or creams and notification to nurse of any medication or cream at the bedside by the DON or designee by 6/6/2026. All staff will be educated on the call light policy and answering call lights promptly and competency by Administrator or designee. All staff who are not in attendance will be educated prior to their next working shift. 3. The DON or designee will audit a random sample of five resident rooms to ensure there are no medications or creams at bedside without assessment and physician order in place weekly times four weeks and monthly times 2 months. The Administrator or designee will audit a random sample of five residents for timely call light response, included in this audit will be interviewing the resident. The results of these audits will be taken to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	06/06/2026

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F0684 SS = E	Continued from page 35 nursing order for “Signature Moisture Barrier Cream with Zinc and Dimethicone- apply to rectum and buttocks excoriation (a raw, irritated sore caused by scratching, chemicals, or friction),” every check and change every day and night shift for excoriation from hair removal,” that was created by director of nursing (DON) B on 4/24/26 and documented as applied twice daily since 4/23/26. A skin alteration evaluation “effective 4/23/26” indicated resident 2 had facility-acquired excoriation of the inner buttocks, which was signed by DON B on 4/29/26. A 4/29/26 skin evaluation indicated resident 2 had a “pink area around the anus but is not open.” Resident 2’s physician was notified on 4/24/26 that resident 2 had requested to use the Nair hair remover, that on 4/23/26, resident 2’s “inner buttocks and anal area were superficially excoriated, and a treatment of “Signature Moisture Barrier Cream with Zinc and Dimethicone [was] initiated.” Resident 2 denied any discomfort. 3. Interview on 5/6/26 at 9:54 a.m. with resident 2 in his room revealed that he purchased the Nair cream online. He asked LPN I if the Nair cream could be used to remove hair from his inner buttocks to make it easier when the staff assisted him with hygiene after toileting when he had a bowel movement. He stated that LPN I told him she needed to “look into it,” and she never got back to him, so he assumed it was “ok.” He then asked CNA H to apply the Nair cream to his inner buttocks before his shower, and she did. CNA H told him that the Nair cream irritated his skin, and another staff member said “it looked like a burn,” and put another cream on it to protect the skin. He stated he could feel the staff touching him, but did not have pain in that area. He did not know if anyone discussed his request with his physician, but he wished that they would because he would like the hair removed. 4. A request was made to administrator A on 5/6/26 at 10:00 a.m. for an interview with CNA H. CNA H was unavailable throughout the survey. 5. Review of CNA H's written statement revealed that resident 2 "asked me to put Nair on his anal area and groin area before [his] shower. I put it on. I asked him if he wanted it wiped off right away, but he told me no, it will come off in the bath. Then [CNA H] transferred [him] to [the] Whirlpool chair and [he] took a bath [for] maybe 20 minutes in the bath. Most [of] it [the Nair cream] came off, but some stayed on, then [the] rest [was] wiped off in the bed	F0684		

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F0684 SS = E	Continued from page 36 after the bath." 6. Observation and interview on 5/6/26 at 1:15 p.m. of registered nurse (RN)/minimum data set (MDS) coordinator J and RN/director of electronic health records (HER)/point click care implementation (PCCI) V changing resident 2's incontinence (involuntary urine or bowel leakage) product revealed he had a light pink area on his right and left buttocks that was intact. RN/MDS coordinator J applied a zinc barrier cream to the pink areas. She stated that was where the excoriation was. 7. Interview on 5/6/26 at 1:34 p.m. with LPN I regarding resident 2's Nair cream revealed that resident 2 asked her about the use of the Nair hair removal creams "a couple of days before he used it." She asked DON B and administrator A if resident 2 could use the Nair cream for hair removal around his anus at his request. Administrator A said that she would "take care of it," and by the time LPN I returned to work a couple of days later to follow up on resident 2's request, he already had a staff member assist him with using the Nair cream. She completed resident 2's skin assessment a few days after he used the Nair cream and stated the area was pink and excoriated, but there were no open areas. She was unsure if the area was a chemical burn. 8. Interview on 5/7/26 at 2:31 p.m. with DON B revealed she became the DON the day after the incident with resident 2 occurred, on 4/23/24. She was told that resident 2 insisted that the staff members use the Nair cream, and they followed his wishes. She thought that administrator A told resident 2 that he could not use the Nair cream. She was unaware that resident 2 had the Nair cream in his room until after it was used. She confirmed that resident 2 was unable to apply the Nair cream himself due to his quadriplegia and that a staff member assisted him by applying the cream. A request from a resident to use a hygiene product, such as Nair cream, would require a physician's order and that a chemical hygiene product would be required to be applied by a nurse, as that is not part of the delegated tasks and responsibilities of a CNA. Nair was a chemical hair remover intended for use on non-sensitive areas of the body. She stated "everyone is different," but agreed that the Nair cream could cause a chemical burn if the directions were not followed and used on a resident's anal area and inner buttocks. 9. Interview on 5/7/26 at 3:44 p.m. with	F0684		

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F0684 SS = E	Continued from page 37 administrator A revealed she became aware that a staff member applied Nair hair removal cream to resident 2's anal area and inner buttocks the day after it happened (4/24/26). She stated that resident 2 asked her if he could use Nair hair removal cream the day before he used it on 4/22/26. She told resident 2 that he could not use it in sensitive areas because it could cause a chemical burn. She was unaware that resident 2 had already ordered the product online and had it in his room. LPN I was told by administrator A that resident 2 was not allowed to use the Nair cream. She expected that CNA H would have asked the licensed nurse before using the Nair cream, and that the nurse would have determined if the resident could use the cream and requested a physician's order. 10. Review of the provider's revised July 2018 Medication Ordering, Receiving, and Storage policy revealed: "The Facility shall store all medications and biologicals in a safe, secure and orderly manner." 11. Review of the 12/2/25 SD DOH complaint report revealed that resident 6 indicated that it took the staff an hour at times to answer her call light while she resided at the facility from 7/25/25 through 8/19/25. 12. Review of resident 6's electronic medical record (EMR) revealed her 8/19/25 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her diagnoses included cellulitis (tissue infection) of the left lower limb, gait (walking) abnormality, weakness, and urge incontinence (involuntary urine or bowel leakage). Her 7/28/25 care plan indicated she had a wound vac (a medical treatment that applies controlled suction to a wound to accelerate healing) on her left foot, she required partial staff assistance with dressing, total staff assistance for moving in bed, and two staff members to assist her with transferring, using the bathroom, and walking. 13. Interview on 5/5/26 at 2:24 p.m. with resident 13 revealed that she had to sometimes wait 30-60 minutes for the staff to answer her call light and had called 911 a "few times" when the staff took too long to respond. No incidents had occurred when she had to wait for the staff to answer her call light, but it made her upset when she had to wait a long time. She talked to a nurse manager about it and who defended the staff.	F0684		

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F0684 SS = E	Continued from page 38 14. Review of resident 13's EMR revealed her 5/5/25 BIMS assessment score was 15, which indicated her cognition was intact. Her diagnoses included neuromuscular bladder dysfunction (loss of bladder control caused by nerve damage), epileptic seizures (when brain cells misfire all at once), anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), repeated falls, and weakness. Her 4/29/26 care plan indicated that the staff was to notify the nurse as soon as possible if she had a seizure, to educate her to use her call light, and to wait for the staff's assistance instead of calling out or yelling for help. She was at risk for falling, and the staff was to educate her on the importance of using her call light and waiting for help before transferring. She had a urinary catheter (flexible tubing placed in the bladder to drain urine). She required the assistance of two staff members and a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) for transferring, substantial staff assistance for moving in bed, dressing, and using the toilet. 15. Interview on 5/5/26 at 2:35 p.m. with resident 1 revealed he regularly had to wait, 15 minutes or more, for the staff to answer his call light. He reported that the staff sometimes came in and turned his call light off without assisting him, said they would be back, but they did not come back, and he had to turn it back on and wait another 15 minutes for the staff to answer his call light. No incidents occurred when he had to wait for the staff to answer his call light, but it made him mad when he had to wait for a long time. He reported that he talked to administrator A about it, and he felt that "nothing" was done to correct the issue. 16. Review of resident 1's EMR revealed his 4/6/26 BIMS assessment score was 15, which indicated his cognition was intact. His diagnoses included cerebrovascular disease affecting the left side (weakness or paralysis from a stroke on the left side of the body), anxiety, depression (a feeling of sadness and loss of interest in doing things, which stops you from doing normal activities), and abnormalities of gait and mobility. His 5/4/26 care plan indicated he was independent with transferring, and he needed two staff members to assist him with dressing and using the bathroom.	F0684		

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F0684 SS = E	Continued from page 39 He was at risk for falling, and the staff were to encourage him to use his call light for assistance. 17. Interview on 5/5/26 at 2:52 p.m. with resident 11 revealed she occasionally had to wait longer than 15 minutes for the staff to answer her call light. She stated that she was independent with most things and did not need a lot of help from the staff, but when she did, she expected the staff to help her because “I am as important as everyone else.” She stated, “It ruins my sense of humor” when she had to wait a long time for the staff to answer her call light. She stated that no incidents had occurred when she had to wait for the staff to answer her call light. 18. Review of resident 11’s EMR revealed her 5/5/26 BIMS assessment score was 9, which indicated her cognition was moderately impaired. Her diagnoses included adjustment disorder (struggling to cope with changes or stress) with mixed anxiety and depression, repeated falls, abnormality of gait and mobility, and weakness. Her care plan indicated she needed partial staff assistance with dressing and personal hygiene. She was at risk for falling and was educated to call for staff assistance because she had a splint (a medical device used to immobilize a body part while it healed) on her left hand. 19. Interview on 5/6/26 at 1:45 p.m. with certified nursing assistant (CNA) FF revealed she was told she needed to answer the call lights as soon as possible. She wore a pager that alerted her when a resident used their call light, and there was a kiosk (a digital terminal placed in a high traffic area to provide information) in the hallway that indicated which resident had their call light on and what time it turned on. 20. Interview on 5/6/26 at 1:50 p.m. with licensed practical nurse (LPN) L revealed that resident call lights were to be answered within ten minutes, but in the mornings, it took a while longer. She would not turn the call light off until the resident was helped because the resident might get forgotten about. LPN L reported that the CNAs carried pagers to alert them of whose call lights were turned on, and some nurses carried them, but she did not think they had to. She monitored the call light kiosk to know which resident needed assistance. Everyone was responsible for answering the residents' call lights, and administrator A monitored the call light time	F0684		

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F0684 SS = E	Continued from page 40 reports. 21. Interview on 5/6/26 at 2:23 p.m. with registered nurse (RN)/minimum data set (MDS) coordinator J revealed that the residents' call lights were expected to be answered within five minutes and that all staff were responsible for answering the call lights. The CNAs wore a pager, and the nurses did not have to wear one. The nurses and the managers carried walkie radios. 22. Review of the call light report for resident 13's room from 4/5/26 through 5/5/26 revealed there were 40 instances where her call light was on for longer than 15 minutes, up to 59 minutes. 23. Review of the call light report for resident 1's room from 4/5/26 through 5/5/26 revealed there were 33 instances where his call light was on for longer than 15 minutes, up to 56 minutes. 24. Review of the call light report for resident 11's room from 4/5/26 through 5/5/26 revealed there were 10 instances where her call light was on for longer than 15 minutes, up to 45 minutes. 25. Resident 6's call light report was not available because she no longer resided in the facility. 26. Interview on 5/7/26 at 2:57 p.m. with administrator A revealed that the residents' call lights were to be answered within ten minutes, and everyone was responsible for answering the call lights. The staff were to leave the residents' call light on until the resident was helped. All staff were to carry the pagers, including CNAs, nurses, and managers. She then stated, "I am not wearing mine." She or the manager on duty reviewed call light reports daily to monitor for long call light wait times. If the call light report indicated that a resident had a call light on for over 10 minutes, the manager on duty would talk with the resident. 27. Review of the provider's 11/28/25 Call Lights policy revealed the facility was to ensure that the resident's call for staff assistance was responded to promptly. It indicated that if immediate assistance could not be provided and there was not an	F0684		

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F0684 SS = E	Continued from page 41 emergent need, the call light could be turned off and the resident would be notified that the staff would be back to assist them shortly.	F0684		
F0689 SS = E	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 South Dakota Department of Health (SD DOH) Facility Reported Incident (FRI), record review, interview, observation, and document review, the provider failed to ensure the safety for one of one resident (10) who spilled coffee on his hand and leg that was not at safe temperature, two of seven observed residents (11 and 12) who were drinking hot liquids and did not have identified safety inventions followed, and for one of one sampled resident (8) who fell in the shower when certified nursing assistant (CNA) (AA) did not follow his care plan (personalized plan that addresses a resident's care needs, goals, and interventions). Findings include: 1. Review of the provider's 1/5/26 SD DOH FRI report revealed that on 1/4/26 at 8:26 a.m., registered nurse (RN)/former director of nursing (DON) MM witnessed resident 10 spill his coffee. The video camera footage indicated that resident 10's coffee was served to him at 7:29 a.m. He went to wave at the staff while drinking his coffee and bumped his coffee cup, spilling it on his left hand and pant leg. His initial 1/4/26 skin assessment found that the skin areas where the coffee spilled were pink, and his 1/5/26 and 1/6/26 skin assessments determined that there were no injuries. The coffee's temperature from the kitchen's coffee pot on 1/4/26 at 7:00 a.m. was 170 degrees. The kitchen filled a carafe with coffee for meals. The coffee's temperature was not checked after being placed in the carafe on 1/4/26. Resident 10 had a	F0689	1. Resident #8 is discharged from the facility. Resident 10, 11 and 12 had a new hot beverage assessment completed on 5/20/2026. All residents at risk for deficient practice. A new hot beverage assessment was completed for all residents on 5/20/2026. 2. All licensed nurses educated on accuracy of completing the hot beverage assessment and proper notification to dietary to update the tray card to reflect any necessary changes for hot beverages by the DON or designee by 6/6/2026. All nursing staff educated on not leaving a resident unattended in the shower/bath by DON or designee by 6/6/26. All staff who are not in attendance will be educated prior to their next working shift. The Administrator or designee will educate all dietary staff on proper serving temperature of hot beverages per the hot beverage policy by 6/6/2026. All staff who are not in attendance will be educated prior to their next working shift. 6/3/26 SC 3. The DON or designee will audit all hot beverage assessments for accuracy and implementation completed weekly times four weeks and monthly times two monthly. The administrator or designee will audit hot beverage logs for beverages being served at appropriate temperatures weekly time four weeks and monthly times two months. The results of these audits will be brought to the monthly QAPI for further review and recommendation to continue or discontinue the audits.	06/06/2026

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F0689 SS = E	Continued from page 42 new hot liquid safety evaluation completed, and his tray card and care plan were updated. 2. Review of resident 10's electronic medical record (EMR) revealed he was admitted to the facility on 5/2/22. His 5/5/26 Brief Interview of Mental Status assessment score was a 15, which indicated his cognition was intact. His 12/20/25 hot liquid safety evaluation indicated he was not at risk, and interventions were to fill the cup/mug half to three-fourths full. His 1/5/26 hot liquid safety evaluation indicated he was not at risk for burning himself, and the interventions in place were to use a lid on the cup/mug. His 3/9/26 hot liquid safety evaluation indicated he was not at risk of burning himself and that he was to drink hot liquids in a sitting position due to his unsteady walk and balance. Resident 10's January 2026 treatment administration record (TAR) indicated his skin was monitored for three days after the incident on 1/4/26. His care plan and dietary card were updated with the intervention to use a lid on his cup/mug on 1/5/26, and were updated after his newest hot liquid safety evaluation on 3/9/26. 3. Interview on 5/7/26 at 10:35 a.m. with resident 10 revealed that he recalled spilling his coffee on his hand and leg in January 2026, and he did not have any injuries. 4. Interview on 5/5/26 at 9:35 a.m. with dietary aide EE revealed that hot water and coffee were available in the dining room for the residents to serve themselves during the day between meals, and the staff served the residents their drinks at meal times. 5. Observation on 5/5/26 from 11:18 a.m. through 11:32 a.m. in the dining room revealed that residents 11 and 12 were drinking coffee from a coffee cup without a lid. 6. Interview on 5/6/26 at 1:45 p.m. with CNA FF revealed she thought that if a resident had interventions related to drinking hot liquids safely, they would be on the resident's care plan or kardex (a report of the resident's care needs and interventions).	F0689		

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F0689 SS = E	Continued from page 43 7. Review of resident 11's 2/26/26 hot liquid evaluation score was 4, which indicated she was at risk of burning herself and that she was to use a lid on her cup/mug. Her care plan did not include her hot liquid safety interventions. 8. Review of resident 12's 2/21/26 hot liquid evaluation indicated he was not at risk for burning himself, but he was to use a lid on his cup/mug. His care plan did not include his hot liquid safety interventions. 9. Interview and review of the January 2026 through May 2026 coffee temperature monitoring logs on 5/6/26 at 8:40 a.m. with dietary manager (DM) Y revealed that the coffee temperature documented on 1/4/26 was 170 degrees Fahrenheit (F), and it was to be at 155 degrees F before serving to the residents. All other temperatures after 1/4/26 were documented before meals and were at acceptable serving temperatures. There were three residents who were required to use coffee cups with a lid. Those three residents were written on the whiteboard in the kitchen and did not include residents 11 and 12. She stated that whoever completed their hot liquid safety evaluation was to let her know if they were at risk of burning themselves and if they required safety interventions. She would then update the whiteboard in the kitchen and the resident's diet card. The dietary aide served the drinks to the residents. 10. Interview on 5/6/26 at 3:08 p.m. with registered nurse (RN)/minimum data set (MDS) coordinator J revealed that hot liquid safety interventions should be on the residents' care plans. Director of nursing (DON) B and regional nurse consultant (RNC) M completed the residents' care plans. DM Y was notified of changes to residents' hot liquid evaluations during the daily interdisciplinary team (IDT) meeting, and she was to update her dietary staff. 11. Interview on 5/7/26 at 2:57 p.m. with administrator A revealed she expected the dietary staff to follow their policy regarding temping and serving the coffee to residents. She expected residents 11 and 12 to use cups/mugs with lids as indicated on their hot liquid safety evaluation, and	F0689		

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F0689 SS = E	Continued from page 44 for that information to be updated on the white board in the kitchen, on their diet cards, and in their care plans. The IDT was to discuss resident hot safety evaluation interventions in the daily morning meeting. Administrator A acknowledged that not following residents' 11 and 12 hot liquid safety interventions put them at risk for burning themselves. 12. Interview on 5/7/26 at 3:43 p.m. with DON B revealed she expected the hot liquid safety evaluation interventions to be on the residents' care plan and that they were to be updated by the DM or the nurse who completed the hot liquid safety evaluation. The evaluations were completed by the scheduled nurse or the MDS coordinator. 13. Review of the provider's 11/18/25 Hot Liquids Safety Evaluation policy revealed that "the temperatures that hot beverages should be served at are governed by the palatability and by the risk for a burn. The Hot Liquid Safety Evaluation will be completed on all residents." "Follow these safety precautions for hot liquid safety: Serve the hot beverages between 140 and 155 degrees. Hot liquid temperatures should be taken and recorded at every meal and/or when prepared to ensure the temperature is within the above parameters before being served. Hot beverage dispensers should be removed from the dining rooms or other areas where residents have accessibility without supervision." It indicated that if the resident scored 3 or greater, then they were to implement interventions for safe handling of hot liquids and add them to the resident's care plan. 14. Review of the provider's 9/9/25 SD DOH FRI report revealed that on 9/8/25, resident 8 was left in the shower unsupervised by CNA AA, and he fell on his knees, which bruised. His care plan indicated he required supervision/touching assistance in the shower. All staff were educated to follow resident care plans. 15. Review of resident 8's EMR revealed he was admitted to the facility on 8/21/25 and discharged on 11/20/25. His diagnoses included hepatic failure	F0689		

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F0689 SS = E	Continued from page 45 (when the liver shuts down), cirrhosis of the liver (severe, permanent scarring of the liver caused by long-term damage or disease), kidney failure (when the kidneys shut down), hypotension (low blood pressure), hepatic encephalopathy (a decline in brain function caused by severe liver disease), and hemiplegia (a form of paralysis that causes weakness or the complete inability to move just one side of the body) affecting the left side. Resident 8 had an 8/21/25 physician's order for midodrine (a medication to raise the blood pressure) and furosemide (a diuretic [medication to flush extra fluid from the body]). He had an 8/23/25 physician's orders for occupational therapy (OT), and physical therapy (PT). His 8/21/25 fall risk evaluation indicated he was at high risk for falling due to "diagnoses of hypotension-currently being treated for with medication, cognitive impairment, [and] left sided hemiparesis". His 8/29/25 care plan indicated he was at risk for falling related to diuretic use, cirrhosis of the liver, renal failure, hemiparesis to his left side…." He was to use assistive devices during ambulation to prevent falling, and the staff were to assist him with showering or bathing, by providing supervision/touching assistance with bathing, and to be present when he showered. Resident 8 had a 9/8/25 progress note that indicated he was found on the floor in the shower room lying on his stomach. The CNA was in the room when the nurse arrived, but the resident was in the shower by himself when he fell. He had bruising to his knees and required two staff members to help him off the floor. 16. Interview on 5/7/26 at 11:50 a.m. with administrator A revealed that she expected CNA AA to follow resident 8's care plan and stay with him in the shower. She acknowledged that not all staff were educated to follow the residents' care plans following the incident on 9/8/25as indicated in the SD DOH FRI report. 17. Review of the provider's 5/14/25 Falls Management policy revealed "it is the policy of the facility to identify and implement appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence."	F0689		

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F0689 SS = E	Continued from page 46 18. Review of the provider's 5/14/25 Care Plans policy revealed "it is the responsibility of direct care members to familiarize themselves with the care plans and review them routinely for changes."	F0689		
F0761 SS = E	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 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 South Dakota Department of Health (SD DOH) facility-reported incidents (FRIs), personnel files, record review, observation, interview, and policy review, the facility failed to ensure safe and secure storage of controlled medications (medications with risk for abuse and addiction) for one of one sampled resident (4) with 13 missing Hydrocodone /APAP (acetaminophen) (a medication to treat moderate to severe pain) 5-325 milligram (mg) tablets and one of one sampled resident (5) missing one lorazepam (a medication to treat anxiety) 0.5 mg tablet. Findings include:	F0761	1. Resident #4 received new card of hydrocodone/ APAP medication. Resident #5 received a replacement dose of lorazepam. There were no adverse outcomes related to missing medication. All residents are at risk for deficient practice. A house wide audit was conducted of all narcotics in the facility and were accounted for. 2. The Administrator and DON reviewed the Storage of Medication Policy. All licensed nurses will be educated on Storage of Medications policy by the DON or designee by 6/6/2026. All licensed nurses not in attendance will be educated prior to their next working shift. 3. The DON or designee will audit all narcotics in the facility to ensure counts are accurate and there are no missing medications weekly times four weeks and monthly times two months. The results of the audits will be brought to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	06/06/2026

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F0761 SS = E	Continued from page 47 1. Review of the provider's 1/20/26 SD DOH FRI revealed that at approximately 8:30 a.m. on 1/20/26, contracted travel registered nurse (RN) N entered resident 4's room with his medication card, which contained his PRN (as needed) Hydrocodone/APAP 5-325 mg tablets, and the rest of his morning medications for administration to the resident. Approximately two hours later, RN N discovered she had misplaced the medication card of 13 tablets of Hydrocodone/APAP and reported that the medication card was missing to former director of nursing (DON) E between 12:45 p.m. and 1:00 p.m., and an investigation was started. Camera footage revealed that throughout the morning and early afternoon on 1/20/26, numerous staff members and resident 1 entered resident 4's room. Certified nursing assistant (CNA) P entered resident 4's room with his breakfast tray shortly after 8:30 a.m. and immediately exited the room. At 9:02 a.m., housekeeper K entered his room and exited at 9:08 a.m. Contracted travel CNA O entered his room at 9:09 a.m. to assist resident 4 in getting up and ready for the day, and she exited the room at 9:20 a.m. At 11:18 a.m., CNA Q entered resident 4's room and took him to lunch. At 12:03 p.m., resident 4 and resident 1 entered resident 4's room together. At 12:12 p.m., contracted travel RN N entered resident 4's room and then exited, and at 12:18 p.m., resident 1 exited. At 12:23 p.m., resident 4 left his room and attended therapy. The final report noted that contracted travel RN N stated she had taken the medication card containing 13 tablets of resident 4's Hydrocodone/APAP to his room that morning to save time, as she was in a hurry and the resident often requested a tablet of that medication in the mornings. A count of all the residents' controlled medications was completed by regional nurse consultant (RNC) M and contracted travel RN N, and all counts were accurate except for resident 4's known missing Hydrocodone/APAP. The medication card containing resident 4's Hydrocodone/APAP 5-325 mg tablets was never located after thorough searches of the facility during the investigation. Review of the personnel files for contracted travel RN N and contracted travel CNA O revealed that both had completed orientation training and education through their employing agency and received additional training and education through	F0761		

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F0761 SS = E	Continued from page 48 the facility. There were no prior disciplinary actions in their files. Their education included topics such as misappropriation of resident property and drug diversion (illegal transfer or use of prescription drugs). Contracted travel RN N's last working shift at the facility was on 1/20/26, when she was suspended from working at the facility pending the investigation, and her work contract with the facility was terminated on 1/21/26. Contracted travel CNA O remained on the facility's schedule and was allowed to work. Her last shift at the facility was on 3/31/26. 2. Review of resident 4's electronic medical record (EMR) revealed that he had a seizure and fell in his home on 11/27/25, which resulted in compression fractures (bones in the mid-back have collapsed or become crushed, causing back pain) of his T4, T5, and T6 vertebrae (the 4th, 5th, and 6th bones) and his admission to the hospital. He admitted to the facility on 12/12/25 and received therapy services. His diagnoses included seizure disorder (a condition with recurring, unpredictable seizures), cardiac arrest (the heart suddenly stops beating, cutting off blood flow to the brain and other vital organs), and lower extremity weakness. His 3/24/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. 3. Interview on 5/6/26 at 4:50 p.m. with resident 4 in his room revealed that he recalled the incident that involved his missing Hydrocodone/APAP medication card in January 2026. Resident 4 said he gave staff permission to search his room for the missing medication card, and he was questioned by the police. Resident 4 denied keeping the card and taking the medication himself, stating that he never saw a medication card left in his room and was unsure whether the nurse had even brought the Hydrocodone/APAP medication card into his room that day. Resident 4 stated that he had been taking that medication to help control his pain from the compression fractures in his back. He remembered eating breakfast in his room that morning, and that a CNA brought him his meal tray and another CNA later assisted him to get ready for the day, but he could not recall their names. Resident 4 said the nurse brought him his medications, but he could not recall her name. He did not see the nurse or CNA with a medication card when either left his room. Resident 4 was not sure what had happened to the missing medication card, but the pharmacy replaced	F0761		

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F0761 SS = E	Continued from page 49 the medication for him. Resident 4 said he requested one of his PRN Hydrocodone/APAP medication tablets for his pain that morning and that it was administered to him by contracted travel RN N. He stated that his missing Hydrocodone/APAP tablets were never found. 4. Interview on 5/7/26 at 11:15 a.m. with housekeeper K regarding the missing medication card of Hydrocodone/APAP revealed that she recalled the incident involving resident 4's missing medication card of Hydrocodone/APAP. She cleaned resident 4's room the morning that the medication card went missing and thought she entered his room between 9:00 a.m. and 9:30 a.m. Housekeeper K did not see a medication card in his room or in the trash. She indicated that checking resident trash was a daily task on their list to complete, to look for residents' personal items that may have been thrown away unintentionally, such as glasses, hearing aids, and dentures. 5. On 5/7/26 at 12:08 p.m., a call was placed to CNA P, which was unanswered. A voicemail message was left requesting a return call. No return call was received during the survey. 6. Interview on 5/7/26 at 12:23 p.m. with CNA Q revealed that she remembered contracted travel RN N looking for a missing medication card for resident 4 during a morning shift she worked. On the day that the resident's medication went missing, she entered resident 4's room just before lunch and assisted him to the dining room. She heard from other staff members that a medication card for resident 4 was left in his room by contracted travel RN N and was not found after the room was searched. Contracted travel RN N told CNA Q that she was asked to leave her shift and would be leaving the facility between 3:00 p.m. and 4:00 p.m. CNA Q was unsure whether resident 4's missing medication card was found. 7. A review of the educational material provided to the nursing staff regarding the 1/20/26 incident of resident 4's 13 missing Hydrocodone/APAP tablets revealed that the information was typed and titled "Education." No date was typed or written on the 1-page document. The education document provided to the nursing staff stated, "Do not take medication cards into resident rooms." "Do not leave meds at bedside." "If you notice any medications left in the	F0761		

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F0761 SS = E	Continued from page 50 room, notify the charge nurse or nursing administration immediately for removal." "Sign below:" 14 nurses signed that education document, but education was not provided to all nurses regarding the 1/20/26 incident of resident 4's missing medication card. 8. Review of the provider's 4/8/26 SD DOH FRI revealed that at approximately 6:00 a.m., during the shift change, licensed practical nurse (LPN) L and contracted travel LPN T were completing the routine change of shift controlled medication count of the controlled medications in one of the two facility's medication carts. During that count, it was discovered that one 0.5 mg lorazepam tablet was missing from resident 5's lorazepam morning dose medication card. The packaging on the back of that lorazepam medication card had a small hole, and no tablet was in it. On 4/8/26, the medication cart and surrounding areas were searched, but the missing 0.5 mg lorazepam tablet was not found. Director of nursing (DON) B checked all other controlled medications and found no other discrepancies. It was discovered that the nurses were not fully removing the controlled medication cards from the narcotic (controlled pain medications) locked drawer to obtain a clear view of all the pills, and were not comparing the actual number of pills in each medication card with the controlled drug record forms to verify that those counts matched. The nursing staff was unsure how long resident 5's lorazepam tablet had been missing. The investigation concluded that resident 5's missing lorazepam 0.5 mg tablet was accidentally ejected from the medication card at some point, unnoticed, and potentially swept up by housekeeping staff. 9. Review of resident 5's EMR revealed that she admitted to the facility on 1/11/23. Her diagnoses included weakness, repeated falls, abnormal gait (any waling pattern that deviates from the usual walk), delusional disorder (false beliefs and distorted views of reality), bipolar disorder (a mental health condition that causes extreme shifts in mood, energy, and activity levels), anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and dementia (a group of symptoms affecting memory, thinking, and social abilities) with behavioral disturbance. Her 4/4/26 BIMS assessment score was 07, which	F0761		

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F0761 SS = E	Continued from page 51 indicated her cognition was severely impaired. 10. Interview on 5/5/26 at 10:47 a.m. with resident 5 revealed that she did not recall that one 0.5 mg lorazepam tablet was missing on 4/8/26 or if the nursing staff reported it to her. 11. Phone interview on 5/5/26 at 11:50 a.m. with resident 5's representative revealed that the facility contacted her and discussed any changes in resident 5's care. The staff would contact her by phone and let her know if any new medications were ordered or if medications were changed. She stated, "I talk to them all the time, and they are on top of it." She stated that she was probably notified of the missing 0.5 mg lorazepam tablet and had no concerns regarding that incident. 12. Interview on 5/6/26 at 4:35 p.m. with LPN L related to resident 5's missing 0.5 mg Lorazepam tablet revealed she could not recall that resident 5 was missing a 0.5 mg lorazepam tablet during the controlled medication count at shift change the morning of 4/8/26. She did not recall if she had completed a thorough search of the medication cart and the surrounding area to locate the missing medication, or if contracted travel LPN T had. She was not sure who had notified the nurse supervisor or the DON or whether the missing lorazepam tablet was found. 13. Interview on 5/7/26 at 11:50 a.m. with contracted travel LPN T revealed that she was the nurse going off duty the morning of 4/8/26. When she was completing the controlled medication count with LPN L, it was discovered that resident 5 was missing one 0.5 mg lorazepam tablet from her morning lorazepam dose medication card. She and LPN L searched the medication cart and the surrounding area but did not find the missing tablet. She stated, "I am not sure how long it was missing." She said she did not report the missing medication to the nursing supervisor or the DON, but LPN L reported it to the unit manager, LPN I. She acknowledged that she received education to check both the controlled medication log and the medication card during the count to verify the accuracy of residents' controlled medications. 14. Review of the educational material provided to the nursing staff regarding resident 5's missing	F0761		

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F0761 SS = E	Continued from page 52 lorazepam tablet on 4/8/26 revealed that the information was typed and titled “Attention Nurses:”. No date was typed or written on the 1-page document. The education document stated, “When counting narcotics during shift change, please be sure to pull the card all the way out, count the pills, and check the back of the card to ensure there are no tears or openings. It is also suggested that you look at the book and verify that the number that’s being read to you is correct. If the count is off/wrong, DO NOT LEAVE THE BUILDING. Contact former DON NN, administrator A, AND DON B. If for any reason you cannot get in touch with one of them, call LPN I, whose number is listed in the numbers binder at the nurse’s station. Narcotic audits will also be performed regularly moving forward.” An in-service sign-in sheet indicated that RN R, LPN I, and LPN L received that education on 4/17/26 after it was identified that resident 5’s lorazepam tablet was missing on 4/8/26. No other nurses at the facility received education. Weekly audits regarding accurate narcotic counts began on 4/10/26 following resident 5’s missing lorazepam tablet. 15. Observation and interview on 5/5/26 at 1:30 p.m. with LPN I in the 200 hallway, of the controlled medications and the count sheets in cart one revealed that the medication cart contained controlled medication cards that were stored in a locked box in a locked drawer. Controlled medications were stored that way in all the facility’s medication carts. LPN I stated that two nurses were to count the controlled medications at each shift change, which occurred twice daily or as needed based on staff schedules. She said that whenever possession of the keys changed, a count was completed. A controlled medication count for cart one was completed with LPN I and revealed that residents’ controlled medication cards were stored in the locked narcotic box, and there were no medication count discrepancies. LPN I did not think that education was provided after resident 4’s medication card of 13 tablets of Hydrocodone/APAP, was reported missing. 16. Interview on 5/5/26 at 2:06 p.m. and again at 3:30 p.m. with consultant pharmacist (CP) W	F0761		

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F0761 SS = E	Continued from page 53 revealed that pharmacy reviews were completed monthly for all residents. Resident medications and physician orders were reviewed, and gradual dose reduction (GDR) recommendations were provided to residents prescribed psychotropic medications (drugs that affect brain activities associated with mental processes and behavior). She would review progress notes, care plans, Minimum Data Set (MDS) assessments, and laboratory reports for changes to determine whether medications were contributing factors to residents' changes in condition. She completed a comprehensive review of resident charts every month, and for any new resident admitted to the facility. She stated that the pharmacy strongly encouraged facilities to report any missing medication to the pharmacy staff. 17. Observation and interview on 5/6/26 at 12:00 p.m. with contracted travel LPN S in the hall next to the nurse's station revealed that she had received education to check both the controlled medication log and the medication card during the count to verify the accuracy of residents' controlled medications. A controlled medication count for cart two was completed with contracted travel LPN S, and all controlled medications were securely stored in the locked box inside the locked cart with no medication count discrepancies. 18. Interview on 5/7/26 at 3:10 p.m. with DON B revealed that she expected nursing staff to be at their medication carts when "punching" medications out from the medication cards when preparing medications to administer to residents. Nurses were not to take medication cards into resident rooms. If a medication was missing, DON B expected nurses to search for it by checking cards stored around the missing medication to determine whether it was removed from the wrong medication card, checking whether it was signed out on the wrong narcotic drug sheet, checking the back of the medication card to see if it was stuck in the packaging, looking in the bottom of the medication cart drawer for it, and reviewing all narcotic drug sheets and medication administration records (MARs) for every entry. After the search, if the medication was not found, the nurses were to contact her as quickly as possible, and she would start an investigation. DON B stated that the physician and family were to be notified of missing medications, and residents	F0761		

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F0761 SS = E	Continued from page 54 were to be notified if they were responsible for themselves. She expected the information to be documented in a progress note. DON B stated that if medications were missing, the pharmacy needed to be notified so they could be replaced. DON B stated that she did not know what had happened to resident 4's Hydrocodone/APAP tablets and that contracted travel RN N, taking his medication card down to his room to administer it, was suspicious of drug diversion, as the 13 Hydrocodone/APAP tablets were never found. She said that the facility's camera footage was reviewed on 1/20/26 and confirmed that contracted travel RN N entered resident 4's room that morning with his Hydrocodone/APAP medication card in hand, but exited without it. Law enforcement was notified on 1/20/26 regarding the missing Hydrocodone/APAP tablets belonging to resident 4, and an officer came to the facility and interviewed him. Resident 4 refused to allow the facility nurse, whose name DON B could not recall, to search him for the missing medication card. DON B stated that she did not know what had happened to resident 5's lorazepam tablet on 4/8/26 and that she had checked all other controlled medications that morning and found no other discrepancies. DON B said that the nurses were not removing the controlled medication cards from the narcotic drawer to obtain a clear view of all the pills, and were not comparing the actual number of pills in each medication card with the controlled drug record forms to verify that those counts matched. She thought that resident 5's missing lorazepam tablet was accidentally ejected from the medication card, unnoticed, and swept up by the housekeeping staff. DON B said that all nursing staff were trained to remove the controlled medication cards from the medication carts, and both nurses were to verify that the medication card counts matched the counts on the controlled medication count sheets. She was not sure whether audits had been completed for the missing medications for residents 4 and 5, or whether incidents involving missing medications had been reported to the monthly QAPI meetings for tracking, recommendations, and process improvement plans. 19. Review of the provider's Quality Assurance and	F0761		

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F0761 SS = E	Continued from page 55 Process Improvement (QAPI) reports for 1/28/26, 3/25/26, and 4/21/26 revealed that medication variance reports were included as a section of the facility's QAPI document for review during the facility's monthly meetings. The incident investigation sections of the QAPI reports included one medication variance in the 1/28/26 report that occurred in December 2025. The 3/25/26 report had no medication variances from February 2026. The 4/21/26 report had one medication variance that occurred in March 2026. The "Corrections Section" for 1/28/26 and 3/25/26 indicated that "staff education" was provided and that the facility transitioned to a facility-initiated ordering system, which allowed the facility to enter physician orders, as planned after the order-entry error occurred with resident 3. No February 2026 QAPI report was provided during the survey for review to verify that resident 4's January 2026 medication variance was documented or to determine whether processes were in place to address his missing medication for tracking and trending, recommendations, and discussion. The medication errors section of the QAPI reports included one medication error in the 1/28/26 and 3/25/26 reports. No information was provided about the medication error in the 1/28/26 report. The 4/21/26 report indicated that "Missing Norco" (a brand name for Hydrocodone/APAP) was noted and that "nursing education" and "audits" were being completed "two times weekly" to ensure the accuracy of controlled medication counts. 20. Interview and record review on 5/7/26 at 5:43 p.m. with administrator A, regional nurse consultant (RNC) M (via phone), and RN/vice president of clinical services (VPCS) X revealed that DON B reported missing medication incidents to administrator A and, if determined to be reportable, administrator A completed a report to the SD DOH. Administrator A acknowledged that she reported the missing medications for residents 4 and 5 to the SD DOH. Administrator A stated that medication variances were reported at the monthly QAPI meetings. Administrator A expected that controlled medications	F0761		

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F0761 SS = E	Continued from page 56 be counted by the incoming and outgoing nurses at every shift change. After the controlled medications were counted, she expected both nurses to sign the narcotic drug sheet, which indicated that the controlled medication count was complete and accurate. If the count was inaccurate, a search for the medication was to be conducted, and DON B was to be notified immediately. *She acknowledged that staff not counting the controlled medications at every change of shift by the incoming and outgoing nurses could increase the risk of drug diversion and would make it difficult to determine when the controlled medication went missing. Administrator A, RN/VPCS X, and RNC M indicated that education was provided to all the nurses following the incidents involving resident 4 and resident 5's missing medications, which included the nurses not to take medication cards into resident rooms and to pull medication cards from the medication cart drawer to view all the pills and compare the pill counts to the controlled medication count sheets. Missing medication audits were being conducted, and the results were being reported at QAPI meetings. Resident 4 and resident 5's education documents and audits related to their missing medications were discussed. Administrator A, RN/VPCS X, and RNC M acknowledged that not all nurses received education related to resident 4 and resident 5's missing medication incidents and that audits had not been initiated after resident 4's missing medication was identified. RNC M acknowledged that audits began on 4/10/26 following the missing lorazepam tablet for resident 5, but not all nurses were educated after that incident. Administrator A, RN/VPCS X, and RNC M acknowledged that routine audits to monitor medication passes and controlled medication counts had not been conducted, including verifying that two nurses counted together at every shift change, monitoring the medication count process between nurses, and reviewing the narcotic count sheets for accuracy and nurse signatures. They acknowledged that audits related to missing medications and medication errors had not been tracked and monitored effectively through the facility's QAPI process, and that the QAPI reports provided limited information about the process improvement plan for those identified areas.	F0761		

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F0761 SS = E	Continued from page 57 21. Review of the provider's revised January 2018 Discrepancies, Loss and/or Diversion Of Medications policy revealed, "The DON investigates the discrepancy and researches all the records related to medication administration and the supply of the medication, including medication reconciliation." "A thorough search in all drug storage areas, the resident's room, and other locations where medications may have been use/placed during the medication administration are made to locate any missing container or medication supply." "Accountability of the medication in question should be checked several times in the following days to assure that accountability is being maintained." "The DON investigates the suspected loss and researches all the records related to medication receipt, its use since receipt, all persons involved with medication administration, and the supply of the medication." "The dispensing pharmacy should be notified, and the pharmacy should verify that the medication was actually dispensed." "If the loss involves a controlled substance, all the controlled drug accountability procedures and documentation should be reviewed and audited." "Appropriate agencies, required by state and federal law, will be notified." 22. Review of the provider's revised January 2018 Medication Storage In The Facility policy revealed, "At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed nurses and is documented." "Any discrepancy in controlled substance counts is reported to the director of nursing immediately." "The director or designee investigates and makes every reasonable effort to reconcile all reported discrepancies." "If a major discrepancy or a pattern of discrepancies occurs, the director of nursing notifies the administrator and consultant pharmacist immediately." 23. Review of the provider's revised January 2018 Consultant Pharmacist Services Provider Requirements policy revealed, "The consultant pharmacist provides consultation on all aspects of the provision of pharmacy services in the facility." "Assists in the identification and evaluation of medication-related issues, including the prevention	F0761		

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F0761 SS = E	Continued from page 58 and reporting of medication errors." "Establishes a system of records for receipt and disposition of all controlled medications to enable an accurate reconciliation, and to determine that the drug records are in order and that an account of all controlled medications is maintained and periodically reconciled." "Assists in establishing quality assurance and continuous quality improvement activities regarding the medication use process, prescribing, dispensing, storing, administering, and monitoring of medications in the facility." " Assists nursing in reviewing medication administration records, treatment administration records, and physician orders quarterly within the QAPI process to ensure proper documentation of medication orders and administration of medications to residents."	F0761		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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:	F0609	1. No corrective action can be taken regarding the late reports to the Department of Health. All residents are potentially at risk of having late reporting of any events in which they are involved. 2. Administrator A is no longer employed at the facility. The Regional Nurse Consultant or designee will educate all staff on timely reporting of alleged violations and submission requirements to the DOH. Education will occur no later than 6/6/26. Those not in attendance will be educated prior to their first shift worked. 3. The Administrator or designee will audit all Department of Health reporting to ensure the report is made within the required timeframe. Included in the audits there will be random interviews with five staff members to ensure that they have not witnessed abuse, neglect or elopements that have gone unreported. Audits will be weekly for four weeks and then monthly for two months. The results of these audits will be brought to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	6/6/2026

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F0609 SS = D	Continued from page 59 Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, observation, document review, record review, and policy review, the provider failed to report within the required time frame for one of one sampled resident (1) who eloped (left the facility without staff knowledge) from the facility's front door. Findings include: 1. Review of the provider's 11/3/25 SD DOH FRI revealed that on 10/30/25 at 5:40 p.m., certified nursing assistant (CNA) F observed that resident 1 was outside. He had eloped from the facility's front door and indicated he was going to a wake (visitation before a funeral) for a friend who had passed away. He was easily redirected back into the facility by the staff. Previous administrator C was notified of resident 1's elopement "immediately following" the incident on 10/30/25 by registered nurse (RN) G. On 11/3/25, administrator A, who was in training at the time, filed an initial report regarding resident 1's elopement to the SD DOH. 2. Previous administrator C was no longer at the facility and was not available for an interview during the survey. 3. Interview on 5/7/26 at 9:16 a.m. with administrator A regarding the provider's 11/3/25 SD FRI of resident 1's elopement revealed she was aware of the elopement. It was reported to her on 10/30/25 that he went out the lobby door and not the following front door, which would have been the exit door of the facility. On 11/3/25, after she read the notes and watched the video of resident 1's, she realized it was an elopement. She was aware of the required reporting time of 2 hours for incidents involving serious harm and 24-hour reporting for all other incidents to the SD DOH. Administrator A indicated she had reported the incident within 24 hours, after she determined it was an elopement. Administrator A was the only staff member who had electronic access to report incidents to the SD DOH. She confirmed that the reporting of resident 1's 10/30/25 incident was not reported to SD DOH within the required time frame. 4. Review of the provider's 5/14/25 Abuse and Neglect policy revealed: "All allegations and/or suspicions of abuse must be reported to the Administrator immediately …All allegations of abuse	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435009	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MILBANK	**1103 SOUTH SECOND STREET , MILBANK, South Dakota, 57252**

(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
F0609 SS = D	Continued from page 60 will be reported to your state agency immediately (within 2 hours) after the initial allegation is received."	F0609	1. Resident 14 has discharged. Resident 2 is being transferred per their plan of care. All residents who require assistance with transferring are at risk for improper assistance by staff. All residents' care plans were reviewed and revised if necessary to ensure their transfer status is on their care plan. 6/3/26 SC 2. The DON or designee will educate all nursing staff on ensuring residents are transferred per their plan of care and where to find this information. Education will occur no later than 6/6/26. Those not in attendance will be educated prior to their first shift worked. 3. The DON or designee will audit five random transfers per week to ensure the resident is being transferred per their plan of care. Audits will be weekly for four weeks and then monthly for two months. The results of these audits will be brought to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	06/06/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and policy review, the provider failed to ensure the staff followed the resident's care plan (personalized plan that addresses a resident's care needs, goals, and interventions) for: *One of one sampled resident (14) who was transferred from his wheelchair to the commode (portable toilet) by one of one certified nursing assistant (CNA) GG when he required the assistance of two staff members.	F0657		

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F0657 SS = D	Continued from page 61 *One of one sampled resident (2) who required two staff members present during all of his cares and was assisted by one of one CNA (P), and an accusation of resident abuse was made. Findings include: 1. Review of the provider's 10/14/25 SD DOH FRI revealed that on 10/14/25, resident 14's family member reported to the assistant director of nursing that CNA GG was using "inappropriate words" in front of the family and resident 14 and stood the resident up from his wheelchair without assistance from another staff member "at the counter" in his room. He was to be assisted by two staff members during transfers with a slide board (a smooth, rigid board, usually made of plastic or wood, used to move a person between two seated surfaces) or a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position). The facility's investigation found that CNA GG "transferred [resident 14] alone with one person at the sink." CNA GG confirmed that this was true. 2. Review of resident 14's electronic medical record (EMR) revealed he was admitted to the facility on 09/09/25. His diagnoses included hemiparesis (paralysis of one side of the body) following cerebral infarction (stroke) affecting his left side and weakness. His 9/24/25 care plan interventions indicated that therapy was working with resident 14 on transfers to the commode. His 10/1/25 revised care plan indicated "[One] 1 person slide board transfer from recliner/wheelchair/bed. If toileting 1 [one] person and [an] additional person [to] remove [the] wheelchair and place [the] commode. May use Hoyer [a mechanical lift and sling used to lift a person's full body] as needed for transfers." 3. Interview on 5/6/26 at 9:28 a.m. with resident 14's power of attorney (POA) (someone designated on a legal document to act on behalf of a resident), who participated by phone, revealed that this incident had occurred "a long time ago," and that resident 14 no longer lived at the nursing home. He knew that resident 14's family member was "pretty upset" about this incident. Resident 14 did not fall that day but stated, "he could have." He stated he would ask resident 14 and his family member if they had additional information they wanted to provide related to this situation, and call back if he had any additional information to share. No return call was	F0657		

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F0657 SS = D	Continued from page 62 made. 4. Interview on 5/6/26 at 2:00 p.m. with CNA GG revealed that resident 14 had muscle weakness on one side of his body from a stroke. She felt that resident 14's transfer status had changed several times and that there was a lack of communication on how she was expected to transfer resident 14 that day. She stated that she would review the resident's care plan to determine how to transfer the resident, but she was unsure where the resident's care plan was located. There was a whiteboard in the staff break room that contained resident transfer status, and there was an assignment worksheet that CNAs used that contained a resident transfer status. She stated that they all said something different. She thought resident 14 could stand at the sink while she moved his wheelchair and placed a commode behind him. 5. Interview on 5/7/26 at 9:55 a.m. at the nurses' station with contract travel CNA JJ and CNA FF revealed they both started working at the facility about four days ago. Contract travel CNA JJ stated that the information on how to transfer residents was located in the residents' care plan, but he relied on other staff members to tell him how a resident would transfer. He would ask the nurse or another CNA if he was unsure. He was unaware whether there was a whiteboard in the staff breakroom with resident transfer statuses on it. The assignment worksheet he was provided did not have the resident transfer statuses on it. CNA FF stated she used the Kardex (an abbreviated version of the care plan) located in the resident's EMR. She was shown a paper worksheet on 5/6/26 that had resident transfer information on it. It was located in the nurses' report room. She was unsure if she was to use that sheet or if it was something they were still working on. 6. Interview and review of the paper worksheets on 5/7/26 at 10:06 a.m. with director of nursing (DON) B revealed that the paper worksheets located in the nurses' report room were implemented during the week of 5/1/26. In October 2025, they had a similar worksheet that contained a resident's transfer status, but the previous version did not have as much information on it. The worksheets from 10/14/25 were no longer available to review. She was not the DON in October 2025, but she expected the CNAs to use the paper worksheets or the	F0657		

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F0657 SS = D	Continued from page 63 resident's care plan in the EMR to know the correct way to transfer a resident. Registered nurse (RN)/ minimum data set (MDS) coordinator J updated those worksheets every time there was a change in the residents' care plan or weekly at the leadership meeting. 7. Interview and review of physical therapy documentation on 5/7/26 at 10:44 a.m. with physical therapist assistant/ therapy coordinator (PTA/TC) U revealed she communicated resident 14's transfer status changes to the nursing staff through an email and documented it in a binder in the report room each time there was a change in a resident's transfer status. The nursing staff updated the resident's care plan in the EMR, the whiteboard, and the CNA worksheets. On 10/14/25, resident 14 required the use of a slide board and one staff member to transfer between his bed and chair. He required two staff members if he needed to stand to use the commode. She expected that one staff member would have stood with resident 14 and another staff member would have moved the wheelchair and placed a commode behind him. She stated it would have been unsafe for one staff member to have done that alone because resident 14 had a one-sided weakness and was at risk of falling. She had spoken with CNA GG on 9/30/25 about not following resident 14's care plan for transfers and provided education on the level of assistance and the devices needed to assist him when transferring. She expected the CNAs to transfer resident 14 according to his care plan. She felt that the information provided to the CNAs may not have been updated on a regular basis, depending on where they looked for that information. 8. Interview on 5/7/26 at 11:36 a.m. with administrator A revealed resident 14's family member had filed a complaint on 10/14/25 about CNA GG and how she had transferred resident 14 that day. Administrator A conducted an investigation and determined that CNA GG did not follow resident 14's care plan when she transferred him alone on 10/14/25. She expected that CNA GG would have had a second person assisting with his transfer for his safety and to reduce the risk that he would fall. 9. Review of the provider's 2/9/26 SD DOH FRI revealed that on 2/9/25, resident 2 posted a video	F0657		

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F0657 SS = D	Continued from page 64 on Facebook that certified nursing assistant (CNA) P told him that if he called her a [curse word] again, "that she was going to pull his hair and punch him in the face." In the video, resident 2 stated that "he feels it's his First Amendment right to speak to staff disrespectfully and call them a [curse word] if he wants to." The facility's investigation could not determine if CNA P stated that she was going to pull his hair or punch him in the face. Resident 2 should have had two staff members present when care was provided "at all times." It was determined that CNA P had not been following resident 2's care plan, and the staff member had been "joking around with resident [2] during a conversation." "[Resident 2] feels safe." 10. Review of resident 2's electronic medical record (EMR) revealed he was admitted to the facility on 10/10/25. His diagnoses included quadriplegia (a partial or total loss of function in all four limbs and the torso), anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and depression. His 4/19/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. His care plan indicated he would refuse to talk to the staff or ignore the staff if he got mad. His 10/28/25 intervention indicated "staff will allow [resident 2] time and reapproach at another time." A 1/19/26 intervention indicated that resident 2 was to receive "Cares in pairs [two staff members]." 11. Interview on 5/6/26 at 9:54 a.m. with resident 2 in his room revealed that he recalled the day, a couple of months ago, when he made a Facebook post about a staff member. That staff member was in his room without another staff member present, and he stated that they were talking and he asked her what she would do if he called her a (swear word) and she said she would "punch him and pull his hair." He was unsure if she was joking, and he did not know what happened to her, but he never saw her again. He was upset because after that, DON B and CNA F came to his room to talk to him. He did not want to listen to them and told them to "get the [curse word] out" of his room, but they would not leave. He stated that DON B told him that he was not allowed to post about staff members on Facebook, but that he did not want to listen to her, had asked her to leave several times, and she would not leave his room.	F0657		

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F0657 SS = D	Continued from page 65 12. A request was made to administrator A on 5/6/26 at 10:00 a.m. for an interview with CNA P. CNA P was unavailable throughout the survey. 13. Review of CNA P's 2/10/26 written statement revealed, "I never said that I would pull his hair and punch him. I was in [the] room by myself, and I know he is cares in pairs. I know I didn't follow the care plan…" 14. Interview on 5/6/26 at 11:19 a.m. with CNA F revealed that resident 2 was "very demanding" with the staff, frequently swore, and she always had another staff person with her when she provided his care. When resident 2 requested the staff to leave his room, especially if he was upset, she was told to make sure he was safe and had his call light and then to leave his room. 15. Interview on 5/7/26 at 2:45 p.m. with DON B revealed she became the DON in April 2026. After resident 2 posted on Facebook about a staff member, administrator A told DON B and CNA F to inform resident 2 that he was not allowed to videotape the staff or the residents. She went into resident 2's room that day. He was in bed, and his computer was on his bedside table in front of him. She closed his computer and moved it away from him. Resident 2 was upset and did not want to listen, but she told him that he needed to listen and that administrator A told her that she needed to have that conversation with him. She stated that he swore at her several times, and then he closed his eyes. Resident 2 asked DON B to leave his room, and she did not. She stated she left his room when she had finished talking to him. She confirmed that his care plan stated that the staff was to leave his room and reapproach him regarding his behaviors. Staff members were to have two people in the room when they provided care to resident 2. She was not the DON when the incident with CNA P occurred, but she expected that all staff would follow the resident's care plan, and resident 2 was to have two staff members present for their safety and his. 16. Interview on 5/7/26 at 3:44 p.m. with administrator A revealed that after resident 2 posted on Facebook about a staff member, administrator A told DON B to inform resident 2 that he was not allowed to videotape the staff or the residents. She	F0657		

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F0657 SS = D	Continued from page 66 was not aware that resident 2's computer was closed and moved out of his reach or that he became upset and requested that DON B leave his room. She expected all staff members to respect resident 2's wishes and leave his room when asked and reapproach him later, especially if he was upset. CNA H did not follow resident 2's care plan when she was in his room alone when the accusations were made. CNA P denied making the comments, and resident 2 was unwilling to talk to administrator A or the police at the time. 17. Review of the provider's revised 5/14/25 Care Plans policy revealed "Care plans are accessible to all direct-care staff, including the resident's physician/provider. It is the responsibility of all direct care members to familiarize themselves with the care plans and review them routinely for changes."	F0657		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to provide wound care as ordered by the physician for one of one sampled resident (9) who had a wound vac (a device that uses negative pressure to remove excess fluid and debris from a wound to promote wound healing) dressing that was not changed as prescribed by the physician by one of one registered nurse (RN) (R) and needed emergent medical attention. Findings include: 1. Observation on 5/5/26 at 9:50 a.m. and at 10:57 a.m. of resident 9 in her room revealed she was sleeping and positioned on her left side. There was a wound vac tube under her blanket that connected to the wound vac device on her nightstand. She had intravenous (IV) (used to deliver medication to a person's bloodstream through a needle or tube (catheter) inserted into a vein), and she declined an interview.	F0658	1. Resident 9 is receiving wound care per physician orders. All residents with wounds are at risk for not having their physician's orders followed. All residents with wounds were reviewed to ensure their wound care is being performed per physician orders. RN R no longer works at the facility. 6/3/26 SC 2. The DON or designee will educate all nurses on ensuring the physician orders are followed, manufacturer's guidance for wound vac is followed and if uncertain about applying a wound dressing to call the DON or nurse on call for assistance. Education will occur no later than 6/6/26 and those not in attendance will be educated prior to their first shift worked. 6/3/26 SC 3. The DON or designee will audit 5 random dressing changes for wounds each week to ensure they are completed per physician order. Audits will be weekly for four weeks and then monthly for two months. The results of these audits will be brought to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	6/6/2026

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F0658 SS = D	Continued from page 67 2. Interview on 5/5 at 10:50 a.m. with licensed practical nurse (LPN) I revealed that resident 9 went to the emergency room (ER) on 5/4/26 to have her wound assessed by a physician because it was worsening. She had a Kennedy ulcer (a skin wound that appears suddenly, often in the final days or weeks of life) on her sacrum (area at the base of the spine between the hip bones); she was on IV antibiotics for it, and it took three people to change the wound vac dressing. Nurses were to monitor the wound vac daily and empty the drainage canister when it was full. At first, a wound nurse was coming in to do the wound vac dressing change, but now the nursing staff changed it at the facility. She did not change resident 9's wound vac dressing on her own, but had assisted other staff members with it. 3. Interview on 5/6/26 at 2:23 p.m. with RN/minimum data set (MDS) coordinator J revealed she was the wound nurse. Resident 9's wound vac dressing change was not completed by RN R on 5/3/26 as prescribed by the physician. RN R was instructed to call LPN I, who was the manager on-call (a manager who was available to come in if help was needed), or RN/MDS coordinator J to help with changing resident 9's dressing if RN R needed help. RN/MDS coordinator J changed the dressing on 5/4/26 and found her wound had worsened. She notified resident 9's primary care physician and the infectious disease physician, and they wanted resident 9 to be sent to the ER because she had a lower blood pressure, an elevated temperature on 5/1/26, and her wound worsened. RN/MDS coordinator J stated that the black foam dressing for the wound vac was to be changed every three days due to bacteria build-up, and if it was not changed every three days, then that increased the resident's risk for infection. She felt the infection was not worse, but that there was more skin breakdown because the dressing was not changed on 5/3/26. 4. Review of resident 9's electronic medical record (EMR) revealed her Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She admitted to the facility on 2/26/26, was admitted to the hospital on 4/2/26 for a sacrum wound, and re-admitted to the facility on 4/10/26. Resident 9's 4/2/26 primary physician's progress note indicated her pressure	F0658		

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F0658 SS = D	Continued from page 68 ulcer was a Kennedy ulcer. Her diagnoses included osteomyelitis (a serious bone infection) of the vertebrae (backbone), sacral, and sacrococcygeal (vertebrae at the base of the sacral area and tailbone) region, abnormalities of gait (walking) and mobility, mononeuropathy (damage to nerves causing pain, numbness, and muscle weakness) of bilateral (both) lower limbs, and weakness. Her 4/28/26 Braden Scale (a tool used to assess a person's risk of developing pressure injuries) risk assessment score was 8, which indicated she had a high risk for developing pressure injuries. Resident 9's 4/17/26 care plan indicated she was at risk for altered skin integrity, had pressure ulcer preventative interventions in place, such as frequent repositing, air mattress, and heel protective boots, had a Kennedy ulcer to her sacrum, and her wound treatments were to be completed as ordered by the physician. Resident 9 was dependent on the staff's assistance with eating, dressing, completing personal hygiene care, moving in bed, and transferring. Resident 9 had physician's orders on 4/10/26 for the wound vac and to change the wound vacs dressing three times per week until the wound was healed. A 4/14/26 physician's order to review RN/MDS coordinator J's wound note on 4/14/26 on how to apply and troubleshoot the wound vac, and a 4/24/26 physician's order for ceftriaxone (IV antibiotic) for osteomyelitis of the vertebra, sacral, and sacrococcygeal regions. On 4/30/26, resident 9 had a physician's note that indicated her lab work had improved, to continue IV antibiotics, to see wound care again, and to have the facility send pictures of the wound. On 5/1/26, a progress note by LPN II indicated that resident 9 had a temperature of 100.2 that resolved to 97.0 during her shift. On 5/4/26 her ER physician notes indicated she was seen for a sacral wound. A computed tomography (CT) scan (a painless procedure imaging test) of her abdomen was completed and compared to her previous abdominal CT on 4/2/26. The findings	F0658		

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(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
F0658 SS = D	Continued from page 69 indicated she had a left-sided sacral wound seen with erosion (destruction of tissue) to the level of the bone. The ER physicians' orders were to discharge resident 9 back to the nursing home, continue using the wound vac, to gently clean the wound when the wound vac dressing was changed, and to continue her IV antibiotics. Her diagnoses listed on the ER visit report were cellulitis (bacterial infection of the skin and underlying tissue) and a non-pressure chronic ulcer of the back with unspecified severity. A progress note on 5/4/26 at 3:46 p.m. by RN/MDS coordinator J revealed that she changed resident 9's wound vac dressing because the dressing was not changed on 5/3/26. When she removed the dressing, the wound was odorous. There was a reddish-brown and gray drainage in the wound vac canister. She described the wound as she indicated in the 5/4/26 weekly wound assessment. She updated the resident's infectious disease physician and primary care physician. Both physicians directed her to send the resident to the ER to be evaluated due to resident 9 having a "fever, low blood pressure, and a change of [her] wound." On 5/4/26 at 4:17 p.m. by RN/MDS coordinator J, revealed that resident 9's blood pressure was 92/46 and her other vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) were within normal limits. A progress note on 5/5/26 at 5:42 a.m. by LPN T indicated that the resident came back from the ER on 5/4/26 at 9:30 p.m. no new medication orders, and her vital signs were within normal limits. At the ER, the staff cleaned her Kennedy ulcer and applied betadine (antiseptic) to the wound. LPN T applied the wound vac when the resident returned. On 4/21/26, resident 9's weekly wound assessment for her Kennedy ulcer, completed by RN/MDS coordinator J, revealed she changed resident 9's wound vac dressing, and her wound length was 8.2 centimeters (cm), width was 16.4 cm, depth was 5 cm, and it was a stage IV (4; open wound with full-thickness skin and tissue loss. Bone, tendon, or muscle may be visible) pressure ulcer (skin and/or underlying tissue injury from prolonged pressure). It did not indicate what the wound bed (the moist base or deepest open area of a wound) assessment was. The edges of the wound were red, there was a moderate amount of bloody red drainage, the	F0658		

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F0658 SS = D	Continued from page 70 resident experienced pain, and the wound was unchanged from the previous assessment. There was undermining (when tissue under the skin was destroyed, creating a hidden pocket beneath the wound edges) of the wound at “10 o’clock” (describing a wound using a clock to create a standardized picture of a wound’s location, shape, and size) that measured 6.5 cm, and at “11 o’clock” it measured 6.9 cm. The assessment indicated that the resident was to see a surgeon to evaluate the undermining of the pressure ulcer. On 4/28/26, her weekly wound assessment for her Kennedy ulcer, completed by RN/MDS coordinator J, revealed her wound developed on 3/7/26. The length was 8.6 cm, the width was 13.7 cm, the depth was 4.5 cm, and it was a stage IV pressure ulcer. The wound bed had 60% (percent) of granulation tissue (healthy tissue), 38% slough (a soft, moist, yellow or white slimy material that forms on top of a wound, consisting of dead tissue and bacteria), 2% necrosis (dead tissue that may be black, brown, tan or green), and the edges of the wound were red. There was undermining from “10:30 to 1 o’clock”, and at “12 o’clock” it measured 6 cm deep. There was a large amount of drainage that was pink in color, the resident had pain, and the wound had improved. On 5/4/26, her weekly wound assessment for her Kennedy ulcer, completed by RN/MDS coordinator J, revealed her wound length was 9 cm, width was 15 cm, depth was 3.3 cm, and it was a stage IV pressure ulcer. It did not indicate what the wound bed assessment was. The edges of the wound were red. She had undermining of the wound at “10 o’clock” to “1 o’clock” that was 6 cm. There was black and gray tissue seen at “12 o’clock-3 o’clock” within the wound bed, and scattered darker areas with grey slough. The wound was odorous. She had moderate drainage that was red blood, the resident had pain, the wound had worsened and the physician was notified. Her treatment administration record (TAR) indicated her wound vac dressing change on 5/3/26 was not signed off as completed by RN R, and RN R indicated to see the nurse's notes. There were no nurse’s notes made by RN R regarding the wound vac dressing change not being done. 5. Interview on 5/7/26 at 8:43 a.m. with RN R	F0658		

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F0658 SS = D	Continued from page 71 revealed she did not change resident 9's wound vac dressing on 5/3/36 as ordered by the physician. She stated she only changed the suction canister and that it took two people to change the dressing. She did not receive education on how to change the wound vac dressing and had only assisted with it, and was "scared" to do it by herself. She did not want to bother LPN I, who was on-call, or RN/MDS J that day, so she passed it on to the next shift to have RN/MDS J do it on 5/4/26. She acknowledged that not changing her dressing as ordered by the physician increased resident 9's risk for her infection worsening. 6. Interview on 5/7/26 at 3:43 p.m. with director of nursing (DON) B revealed she expected RN R to change resident 9's wound vac dressing when it was ordered by the physician, and that she should have called for help if she did not know how to do it. She stated that RN R had a competency checklist completed with her nursing agency on 2/12/26 that indicated she was proficient and highly skilled at wound care, wounds, and drains. She acknowledged that not changing the dressing as ordered by the physician put resident 9 at risk for her wound deteriorating and her infection worsening. 7. Interview on 5/7/26 at 4:30 p.m. with RN/MDS coordinator J revealed that she provided hands-on education to RN R in December 2025 related to wound vacs and their dressing changes. She did not have written documentation that she provided her with this education. RN R did not indicate to her that she was uncomfortable changing the dressing. 8. On 5/7/26 at 8:45 a.m. and 2:57 p.m., administrator A stated they did not have a wound vac policy. She expected that RN R would have completed the wound vac dressing change on 5/3/26 and to call for help if she did not know how to. 9. Review of the provider's 11/18/25 Following Physician Orders policy revealed that "all physician orders should be followed as written. The physician should be notified when an order is not followed for any reason…"	F0658		
F0693 SS = D	Tube Feeding Mgmt/Rest re Eating Skills CFR(s): 483.25(g)(4)(5)	F0693	See next page	

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F0693 SS = D	Continued from page 72 §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on the South Dakota Department of Health (SD DOH) Facility Reported Event (FRI), SD DOH complaint report, record review, interview, professional reference review, and policy review, the provider failed to provide appropriate enteral (passing through the digestive tract) feeding care regarding using a new enteral feeding bag for administering formula and safely storing nutritional formula for one of one sampled resident (7) who received nutritional formula through a feeding tube (a tube surgically placed through the abdomen into the stomach to administer liquid nutrition, fluids and medications) when an enteral feeding bag was not replaced with a new bag for administration of nutritional formula to the resident when a new bag was not found by the director of nursing (DON) B. Findings include: 1. Review of the provider's 8/23/25 SD DOH Facility FRI report stated that licensed practical nurse (LPN) BB put a tube feeding nutritional formula bag on resident 7 on 8/20/25 at 5:00 a.m. She had two days off and returned to work on 8/22/25 to find the bag she dated on 8/20/25 was still hanging with nutritional formula in it. The administrator interviewed staff. Director of nursing (DON), B, who was a charge nurse at the time of the report, stated she cleaned and reused the feeding bag because	F0693	1. Resident 7 has been discharged from the facility. There are no other enteral feeding residents in the facility. A review of required supplies and current stock has been completed to ensure supplies are at sufficient levels. 2. The DON or designee will educate the supply clerk to ensure adequate stock of supplies is maintained. Nurses will also be educated to notify the DON immediately if supplies are low or there is a change in orders requiring different supplies. Education will also include how long formula can be in an enteral feeding bag at room temperature per manufacturer's guidance. Education will occur no later than 6/6/26 and those not in attendance will be educated prior to their first shift worked. 6/3/26 SC 3. The DON or designee will check supply stock levels three times a week, as well as observe the enteral feeding to ensure the formula does not linger for longer than 8 hours. Audits will be weekly for four weeks and then monthly for two months. The results of these audits will be brought to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	6/6/2026

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F0693 SS = D	Continued from page 73 there were no more feeding bags available. There was an order placed for more supplies, and they received the wrong bags. Staff were educated on reporting when the supplies were low. 2. Review of the 8/25/26 SD DOH complaint report revealed it referenced the event that occurred in the 8/23/25 SD DOH FRI report. The report complaint indicated that “there was about 300 mls [milliliters of formula] left in the bag, but it was chunky and curdled and pretty solid.” Former DON D was notified and gave direction to rinse the bag out and reuse it, and she (former DON D) would get more supplies in the morning. The report indicated that administrator A was also notified. 3. Review of resident 7’s electronic medical record (EMR) revealed he was admitted to the facility on 7/18/25 and discharged on 8/28/25. He had diagnoses of a stroke affecting his left side, altered mental status, and dysphagia (difficulty swallowing). He had 8/3/26 physician orders for enteral feeding formula Compleat 1.4 calorie, to be given at a continuous rate of 50 ml (milliliters) per hour by a feeding pump, twenty-four hours per day. Review of resident 7’s August 2025 medication administration record (MAR) and treatment administration record (TAR) revealed that his feeding formula was signed off as administered during the night shifts on 8/19/25 by LPN BB, on 8/20/25 and 8/21/25 by DON B, and on 8/22/25 by registered nurse (RN) DD. 4. Interview on 5/6/26 at 11:53 a.m. with DON B revealed that she worked the nights of 8/20/25 and 8/21/25 and noticed they did not have any more formula feeding bags. She had to rinse resident 7’s formula bag out with clear water and reuse the bag to administer his nutritional formula. They were to change the bag every twenty-four hours. She felt someone should have reported when the formula bag supply was low so more could have been ordered, because he was to receive the formula continuously. She filled the feeding tube bag full of formula. The formula did not all fit in the bag, so before the day shift staff came on duty, she added the rest of the formula to the bag, and the formula would run until the night shift staff came back on duty to change the bag. The feeding bag was not insulated. The facility used the Potter and Perry Fundamentals of Nursing, 10th edition, as a reference of professional standards. 5. Interview on 5/7/26 at 8:54 a.m. with registered dietitian Z revealed that once opened, the Compleat	F0693		

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F0693 SS = D	Continued from page 74 formula was good for eight to twelve hours at room temperature. She expected the formula in the feeding tube bag to be hung for a maximum of twelve hours, and felt that going over that time increased the risk for bacterial growth. 6. Interview on 5/7/26 at 3:43 p.m. with DON B revealed she was unsure of who was responsible for ensuring there were feeding tube supplies available to use. She hoped the nursing staff would notify someone to order more when the supply was low. She acknowledged that rinsing the feeding tube bag and having formula in the bag for administering to a resident for over eight hours, increased the risk of infection. 7. Review of the provider's 11/19/24 Enteral Feeding (Tube Feeding) policy revealed it stated, "change formula bags daily and PRN [as needed]. Use new enteral tubing daily and each time a new formula bag is started." 8. Interview on 5/7/26 at 11:50 a.m. with administrator A revealed that education was not completed for all staff as indicated in the SD DOH report. She was unsure of what the ordering process was for the feeding tube bags. She expected the staff to follow the facilities. 9. Review of the Potter Perry Fundamentals of Nursing, 10th edition book revealed it stated to "refer to manufacturer guidelines to determine hang time for enteral feedings. The maximum hang time for formula is 8 hours in an open system". "There is increased risk of bacterial growth in feedings that exceed the recommended hang time." 10. Review of the Compleat formula manufacturer's directions for use did not indicate what the maximum hang time was. It stated, "Once opened, reclose, refrigerate and use within 24 hours."	F0693		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F0755	See next page	

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F0755 SS = D	Continued from page 75 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on a South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to ensure that procedures were implemented to process medication orders to ensure medications were administered accurately for one of one sampled resident (3) who admitted to the facility following a hospitalization for surgical repair of a fractured left hip and did not receive Aspirin 81 milligrams (mg) twice daily as ordered from the 12/19/25 p.m. dose through the 1/18/26 p.m. dose after the order was incorrectly entered into the provider's electronic order system (PCC) by the pharmacy. Resident 3 experienced increased pain, spontaneous bruising, and increased swelling in her lower legs, which required medical intervention and developed Deep Vein Thrombosis (DVTs) (a blood clot that forms in a vein deep inside the body, most commonly in the lower leg or thigh) in both of her lower legs. Findings include: 1. Review of the provider's 1/7/26 SD DOH FRI revealed that during the consultant pharmacist (CP) medication regimen review on 1/2/26, the CP identified the pharmacy's order entry error regarding resident 3's 12//17/25 physician-ordered 81 mg	F0755	1. Resident #3 has been discharged from the facility. Deficient practice was addressed by facility upon discovery of the medication variance. All residents are at risk for deficient practice. Facility discontinued the practice of pharmacy-initiated orders upon discovery of the variance. 2. All licensed nurses and medication aides will be educated on the medication error policy and complete competency by the DON or designee by 6/6/2026. Any staff who are not in attendance will be educated prior to their next working shift. 3. The DON or designee will review 5 random residents weekly times four weeks and monthly times two months to ensure that medications are being given as appropriate. The results of the audits will be brought to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits	6/6/2026

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F0755 SS = D	Continued from page 76 Aspirin, twice daily, to continue for 30 days after her admission to the nursing facility following a left hip surgical repair. The nursing facility utilized a pharmacy-initiated order system in which pharmacy personnel received all physicians' medication orders and entered those medication orders into the nursing facility's order system, which included residents' electronic medical records (EMRs) and their electronic medication administration records (EMARs). The pharmacy received a clarification order on 12/19/25 to decrease the 81 mg Aspirin administration frequency from twice daily to once daily after 30 days. The pharmacy entered the physician's order for Aspirin 81 mg once daily, to start on 1/19/26, into the electronic pharmacy-initiated order system for resident 3. On that same day, the pharmacy entered an incorrect end date for the 81 mg Aspirin twice daily order, which caused a discontinued medication message to be sent in the facility's electronic medical record (EMR) system for resident 3. The pharmacy corrected that discontinued date error immediately on 12/19/25; however, the facility's order system was unable to update the discontinuation date, and as a result, the 81 mg Aspirin twice daily order never reappeared in the EMR as a corrected or continued order for administration to resident 3. Resident 3 last received her 81 mg Aspirin twice daily dose on 12/19/25 at 8:00 a.m. The order entry error resulted in resident 3 not receiving the scheduled Aspirin from the 12/19/25 p.m. dose through the 1/18/26 p.m. dose. She experienced increased pain, spontaneous bruising, and increased swelling in her lower legs, which required medical intervention, and developed DVTs in both of her lower legs. 2. Review of resident 3's EMR revealed that she admitted to the facility on 12/17/25 for therapy services after being hospitalized for surgical repair of her left hip fracture. While hospitalized, she developed a bowel obstruction (a blockage that prevents food, fluids, and gas from moving through the digestive tract) and required a second surgery on	F0755		

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F0755 SS = D	Continued from page 77 12/6/25. Her diagnoses included hypertension (high blood pressure) and chronic obstructive pulmonary disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe). Her Brief Interview for Mental Status (BIMS) assessment score was 12, which indicated she had moderate cognitive impairment. She discharged from the facility and returned home in the care of a family member on 1/16/26. Resident 3's progress notes dated from 12/21/25 through 12/30/25 indicated that she began complaining of increased swelling in her left lower leg on 12/21/25 at 9:04 p.m. On 12/24/25 at 10:53 a.m., a physical therapy (PT) progress note indicated that resident 3 complained of pain in both lower legs during her therapy session, which limited her activity, and she was unable to complete some of her exercises. Therapy staff documented that resident 3 had significant swelling in her bilateral lower extremities. The therapist did not document a pain level for resident 3 but assessed her pain based on her behaviors, including limited standing and walking, as well as difficulty lifting her feet off the floor. On 12/26/25 at 9:48 a.m., a PT progress note indicated that resident 3 had difficulty bearing weight on her legs due to increased weakness and pain in her lower left leg, and the therapy staff had to supervise all of her transfers. Resident 3 rated her pain 5/10 [five out of ten on a zero to ten level of pain scale] at rest and 7/10 [seven out of ten] with movement. She described her pain in the lower left leg at rest as an "ache" and with movement as "sharp". Progress notes on 12/26/25 at 12:04 p.m. and again at 6:00 p.m. indicated that resident 3 described pain in her left leg as "aching" and informed nursing staff that her right leg was "bothering" her, was purple in color, and that the purple bruising was not present earlier in the day. Resident 3 told nursing staff that she had not bumped or hit her leg on anything to cause purple bruising. Nursing staff documented that resident 3 had 3+ (moderate-to-severe) pitting (temporary "pit" or indenting left in the skin after applying pressure) edema (fluid-related swelling) in the right lower extremity (leg).	F0755		

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F0755 SS = D	Continued from page 78 A progress note dated 12/27/25 at 5:46 a.m. revealed that resident 3 verbalized left leg pain to nursing staff and that a dark bruise was noted on her right leg. At 3:00 p.m. that same day, resident 3 requested that her physician be notified about her pain and to order a stronger pain medication to help her with pain control. A physician's order was received to monitor her bruising to the back of her left lower leg every day and night shift until the bruising healed. A progress note dated 12/28/25 at 2:57 p.m. indicated that resident 3 experienced intermittent pain in her right leg. At 5:12 p.m., a PT progress note indicated that an ice pack was applied to resident 3's left lower leg during her therapy session to help reduce her pain and swelling. Resident 3 rated her pain a 3 on a zero-to-ten pain scale at rest and described it as "nagging and aching." A PT progress note dated 12/29/25 indicated that resident 3 attended a PT session. During the session, the physical therapist assistant/therapy coordinator (PTA/TC) U performed edema massage to resident 3's left lower leg to help reduce the tightness and swelling. Resident 3 arrived at that therapy session with a hematoma (a pool of clotted blood that forms outside of blood vessels, caused by injury or surgery) to her left medial (midline) gastrocnemius (two-part muscle located on the back of the lower leg that forms the calf muscle), with significant increased tenderness. There was no warmth or erythema (redness) to the area. Resident 3 had a positive Homans' sign (a clinical exam of flexing the foot upward toward the shin. If that movement causes pain in the calf muscle, that is considered positive and suggests a possible DVT) in her left lower leg. PTA/TC U notified former DON MM and recommended contacting the physician for an order to complete a Doppler exam (a non-invasive test that uses sound waves to assess blood flow through blood vessels). Resident 3 rated her pain at rest as 3 and at 9 with movement on a zero-to-ten pain scale. The resident described the pain as intense and sharp with movement. On 12/29/25 at 2:09 p.m., a progress note indicated that a fax was sent to notify the physician of resident 3's bruising on her right leg and to request a Doppler exam. Another progress note on 12/29/25 at 7:23 p.m. indicated that resident 3 was	F0755		

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(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
F0755 SS = D	Continued from page 79 experiencing intermittent pain in her right leg. Progress notes from 12/29/25 through 12/31/25 indicated that on 12/29/25, a physician's order was received for resident 3 to undergo a Doppler exam, and the appointment was scheduled for 12/31/25. While attending therapy sessions during those dates, resident 3 continued to experience increased pain and swelling in her lower left leg, which limited her ability to stand, walk, maintain her balance, and perform bed mobility without difficulty. The Doppler exam was completed on 12/31/25 and revealed that resident 3 had bilateral DVTs in both of her lower legs. A physician's order was received for resident 3 to take 5 mg of Eliquis, a blood-thinning medication, orally twice daily for seven days, for her diagnosis of acute thrombosis (a sudden blockage of a blood vessel by a blood clot) in unspecified deep veins of the lower extremities. 3. A drug regimen review for resident 3 was completed by consultant pharmacist (CP) W on 1/2/26 and revealed that Aspirin 81 mg twice daily for resident 3 had not been administered since 12/19/26 at 8:00 a.m. and had not been continued as the physician ordered for 30 days. Her findings were documented in her report, and former DON MM was notified of the finding on 1/2/26. A medication variance report was completed five days later, on 1/7/26, by former DON MM regarding resident 3's omitted Aspirin 81 mg doses she did not receive from 12/19/25 through 1/18/26. 4. On 1/7/26, a corrective action plan was initiated, and the interdisciplinary team (IDT) met to review resident 3's bruising on her right lower leg and to complete an interview process with resident 3 and the nursing staff. The pharmacy addressed the order error entered by the pharmacy, which resulted in a medication error involving the aspirin for resident 3. A late-entry nurse progress note on 1/7/26 documented that the physician was notified that resident 3's Aspirin order to be given twice daily, was inadvertently discontinued by the pharmacy, the nursing facility's medical record system was unable to update the original discontinuation date sent on 12/19/25, and that the order for resident 3's Aspirin twice daily never reappeared as a corrected or continued order. A call was held on 1/9/26 with the pharmacy, facility leadership, and corporate leadership to discuss the	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435009	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

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F0755 SS = D	Continued from page 80 root cause analysis, the error, how it occurred, and the process and plan for correction moving forward. On 1/12/26, a letter from the director of pharmacy was sent to the facility leadership outlining the education and training to be provided to the pharmacy staff. Training on 1/13/26 and 1/14/26 provided the pharmacy staff with education for those involved in the ordering error on 12/19/25, as well as a review of training documentation for all order-entry technicians and pharmacists. Updated material on discontinued orders and the impact on the facility was included in the training. In addition, on 1/14/26, three facility nurses involved in resident 3's Aspirin and order confirmation reviews completed training in a course titled "[Facility] LTC Pharmacy Initiated Orders". The pharmacy technology team attended an order entry meeting with the nursing facility's interface team (a specialized group that manages the software system) to review the process for discontinuing medication orders and future medication order start dates. The facility completed transitioning back to a facility-initiated order system rather than a pharmacy-initiated system on 1/28/26. 5. Interview on 5/5/26 at 2:06 p.m. and again at 3:30 p.m. with CP W revealed that pharmacy reviews were completed monthly with all residents. Resident medications and physician orders were reviewed. She would review progress notes and laboratory reports for changes to determine whether medications were contributing factors. She completed a comprehensive review of resident charts every month, and with any new resident admitted to the nursing facility. She indicated that the pharmacy has a team of nursing account managers who consult and provide education to nursing facilities. They can provide education as needed or upon request from the nursing facility. She acknowledged that a process improvement plan was implemented and completed regarding resident 3's pharmacy order error and that training was provided to the pharmacy team and to the nurses involved at the facility in January 2026. 6. Interview on 5/5/26 at 1:15 p.m. and again at 2:24 p.m. with the director of nursing (DON) B revealed that at the time the order entry error occurred with resident 3, the ordering system was pharmacy-initiated, and nurses were unable to enter	F0755		

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F0755 SS = D	Continued from page 81 physician orders into the facility's ordering system. However, she acknowledged that the facility nurses were responsible for confirming the orders that had been accurately entered by the pharmacy. She said that physician orders were sent to the pharmacy by e-fax or e-scribe at the time of resident 3's order-entry error, but that the facility now received the physician orders by e-fax, e-scribe, telephone, verbally, or in writing. 7. Interview on 5/6/26 at 10:21 a.m. with administrator A revealed that there were no medication errors related to order entries in the system since that incident. Nursing staff members now had the ability to put medication physician orders into the system. Administrator A acknowledged that when the error occurred regarding resident 3's medication, the pharmacy initiated the physician orders, the facility nurse confirmed the order, and an order error resulted in the discontinuation of her Aspirin, which was scheduled to be given twice daily. Administrator A said that she thought education on medication errors was provided to nurses regarding resident 3's ordering error. 8. On 5/6/26 at 11:44 a.m., interviews via phone call were attempted, and a voicemail message was left for resident 3 and resident 3's representative. No return calls were received during the survey. 9. Interview on 5/7/26 at 10:00 a.m. with PTA/TC U revealed that resident 3 admitted to the facility on 12/17/25 and had physician orders for physical and occupational therapy (OT). Resident 3 started PT on 12/17/25, started OT on 12/21/25, and experienced progressive pain, swelling, and bruising in her lower legs from admission until DVTs in both lower legs were discovered on 12/31/25. PTA/TC U stated that resident 3 continued her PT and OT therapy sessions five days a week, but at times, her pain and swelling limited her ability to stand, walk, and maintain her balance. She recalled the therapy session with resident 3, during which she identified a positive Homans' sign, notified former DON MM, and recommended that resident 3's physician be contacted to order a Doppler exam. She stated that she was happy with the timely response former DON MM provided by notifying the physician and obtaining an order for the Doppler exam for resident 3.	F0755		

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F0755 SS = D	Continued from page 82 PTA/TC felt that resident 3 not receiving the scheduled 81 mg of Aspirin twice daily could have been a contributing factor in the development of her bilateral lower leg DVTs. 10. Interview on 5/7/26 at 2:50 p.m. with RN/Minimum Data Set (MDS)coordinator J revealed that she received education regarding the incident involving resident 3's medication error. She reported that resident 3 had no further lower-leg pain or problems after starting Eliquis. 11. Interview on 5/7/26 at 5:30 p.m. with RN/Director of Electronic Health Records (EHR)/Point Click Care Implementation (PCCI) V stated that the facility transitioned to a facility-integrated system on 1/28/26 after a pharmacy order entry error involving resident 3 not receiving her medication as ordered was identified. That plan was adopted as the response to that incident. 12. Interview on 5/7/26 at 5:43 p.m. with administrator A, regional nurse consultant (RNC) M, and RN/vice president of clinical services (VPCS) X revealed that on 1/9/26 a call was held with the pharmacy team, the nursing facilities leadership team, and corporate office personnel to discuss the root cause of resident 3's medication error, how it occurred, and the processes and plan for correction to move forward. Administrator A and RN/VPCS X acknowledged that the ordering error resulted in resident 3 not receiving the scheduled Aspirin for approximately two weeks. Resident 3 experienced increased pain, spontaneous bruising, and increased swelling in her lower legs, which required medical intervention and developed DVTs in both of her lower legs. RNC M acknowledged that since the facility-integrated order system was implemented on 1/28/26, the facility did not conduct any audits to verify whether any further medication order entry errors had occurred for all residents, and that no data about that was presented at the monthly Quality Assurance and Process Improvement (QAPI) meetings.	F0755		

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F0755 SS = D	Continued from page 83 13. Review of the provider's revised January 2018 Provider Pharmacy Requirements policy revealed that "The [Facility] Long Term Care Pharmacy agrees to perform the following pharmaceutical services, including but not limited to: Accurately dispensing prescriptions based on authorized prescriber orders." 14. Review of the provider's Medication Errors policy dated 5/14/25 revealed that the "Policy was to ensure medication errors are identified to prevent adverse resident effects. Errors will be documented, investigated, reported, and reviewed for need of interventions and to prevent recurrence." "Medication errors will be reviewed by the Medical Director and Consultant Pharmacist. The review may be done via telephone, during routine visits, or during QAPI discussions." "The medication error will be entered into the Risk Management Section of [Facility System] for trending and tracking purposes." 15. Review of the provider's Following Physician Orders policy dated 11/18/25 revealed that the "Policy was to correctly and safely receive and transcribe the physician's orders so the correct order is followed/administered." "New admission/readmission physician orders and all transcription of orders should be transcribed by a HUC or a nurse and be double checked by a second nurse to ensure that all steps have been carried out to avoid errors." 16. Review of the provider's revised January 2018 Consultant Pharmacist Services Provider Requirements policy revealed, "The consultant pharmacist provides consultation on all aspects of the provision of pharmacy services in the facility." "Assists in the identification and evaluation of medication-related issues, including the prevention and reporting of medication errors." "Establishes a system of records for receipt and disposition of all controlled medications to enable an accurate reconciliation, and to determine that the drug records are in order and that an account of all controlled medications is maintained and periodically reconciled." "Assists in establishing quality assurance and continuous quality improvement activities regarding the medication use process, prescribing, dispensing, storing, administering, and monitoring of	F0755		

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F0755 SS = D	Continued from page 84 medications in the facility." " Assists nursing in reviewing medication administration records, treatment administration records, and physician orders quarterly within the QAPI process to ensure proper documentation of medication orders and administration of medications to residents."	F0755		