DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435079	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED LIVING COMMUNITY	405 FIRST AVE , BROOKINGS, South Dakota, 57006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/2/25 through 12/4/25. United Living Community was found not in compliance with the following requirements: F550, F554, F761, F803, F806, F812, and F883, A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/2/25 through 12/4/25. Areas surveyed included, sufficient staffing, environment, quality of care/treatment, and infection control. United Living Community was found not in compliance with the following requirement: F600.	F0000	A Call Light Response Time policy will be developed by the Administrator or designee and approved by QAPI. Within the policy it will indicate how long it is acceptable for a resident's call light to be on based on acuity of the need, best practice for rounding, and provide examples of other staff within the facility that can be asked to help with resident care. Once the policy is approved by QAPI, competency-based education and training will be done for all staff able to answer a call light. Education and training will be done by the Director of Nursing or designee. The call light response times will be monitored weekly for 12 consecutive weeks. If compliant, audits will reduce to monthly. Audits will be completed by the Director of Nursing or designee.	1/18/2026
F0550 SS = D	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. §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.	F0550		

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
Liz DeBerg	Administrator	1/6/2026

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F0550 SS = D	Continued from page 1 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 interview, record review, and policy review, the provider failed to ensure that one of eighteen sampled resident's (72) right to a sense of dignity and respect was maintained related to wearing incontinence products and experiencing an incontinence episode, and that preferences were followed related to staff assistance with walking. Findings include: 1. Interview on 12/4/25 at 8:14 a.m. with resident 72 revealed that he had a concern with the staffing levels and the amount of time he had to wait to get help since he admitted to the facility on 11/18/25. He waited for over 20 minutes for someone to answer his call light on the morning of 11/19/25. He waited so long that he lost control of his bladder and urinated in bed. He expressed feelings of embarrassment after he wet the bed. He spoke with one of the facility managers about his experience and expressed his displeasure. Since talking to them, he has not had many issues with long call light wait times. He confirmed that he could tell when he needed to go to the bathroom. He had no issues with the feeling of the urge to urinate. He indicated that he had "issues with urination anyway," explaining that as he has gotten older, he has needed to get up more frequently during the night to use the bathroom. He was admitted to the facility about three weeks ago. He was staying at the facility for rehabilitation	F0550	All data will be collected and aggregated in QAPI, and reviewed a minimum of quarterly.	1/18/2026

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F0550 SS = D	Continued from page 2 therapy after having back surgery. At home, he did not usually wear incontinence briefs, but he began wearing them while staying at the facility. When he first arrived, he could not get up on his own. After wetting the bed, he started sleeping in the recliner because he believed it would be easier for staff to help him get to the bathroom. He normally slept in a bed, not in a recliner. He only slept in the recliner for a few nights, then went back to sleeping in the bed. He stated, "I'm someone that had back surgery, so I'm pretty limited in what I'm doing. I'm not just a room number." He stated he was not impressed with how the facility was managed, as he said that he was a manager for his whole career. He guessed that because the facility was short-staffed, there may have been miscommunication between departments. Since he had been progressing in his rehab stay, the therapy department was telling him that he needed to get up and walk more, but "I can't do anything without their [the nursing staff's] help. They put the belt on, and I always have to have someone walk with me." He mentioned that just the day prior on 12/3/25, sometime in the afternoon, he put on his call light and asked one of the nursing aides to help him go for a walk. The aide told him she could not walk with him because she was the only staff member on the unit at that time. He could not remember her name. 2. Interview and call light audit review on 12/4/25 at 12:38 p.m. with director of social services (DSS) M revealed that there were a couple of longer call light wait times on the morning of 11/19/25, the day after resident 72 admitted to the facility. He talked to her about the long call light wait times on 11/19/25. She asked him if he wanted to file a formal grievance, but he declined. She spoke with the evening nursing staff on 11/19/25 about being attentive to residents when they put on their call lights. She spoke with resident 72 the next day on 11/20/25 to see how overnight went with the call light wait times, and he confirmed that he did not have any issues that night. She explained that the hospital information provided to the facility on his admission included information about incontinence briefs while he was a patient there, and they continued to provide the briefs during his stay at the facility. The facility staff included that he wore incontinence briefs on his initial 48-hour care	F0550		

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F0550 SS = D	Continued from page 3 plan. SSD M confirmed that resident 72 spoke to him about the embarrassment he felt when he was incontinent, and that they wanted to treat each resident with dignity. She said, "it's a bummer. He did tell me about the embarrassment. I did not want him to feel like he was 'room number [XXX]... We want him to have a humanized experience.'" 3. Interview on 12/4/25 at 3:31 p.m. with director of nursing (DON) B revealed that when a resident presses their call light, the notification was sent to the facility phones that each nursing staff member carried with them during their shift. She indicated that a reasonable time for a resident to wait for a staff member to answer the call light was about five to ten minutes. She indicated that they were "a little" short staffed on 12/3/25, which was the date resident 72 said that a nurse aide told him that she could not take him for a walk because they were short-staffed. She explained that "it's not our practice to say, 'sorry I can't do that right now because we're short.'" If a staff member was unable to assist a resident when responding to a call light, she expected the staff to explain why and to tell the resident when they would return to help. 4. Phone interview on 12/4/25 at 4:14 p.m. with unlicensed assistive personnel (UAP) L revealed she picked up a 2:00 p.m. shift on 12/3/25. She confirmed that she told resident 72 that she could not help him walk when he asked because "I was the only one on the floor, and I had to count the cart, and they asked me to help bring people back from bingo." From 2:30 p.m. to 3:00 p.m., she was the only certified nursing assistant (CNA) on that resident's unit. She counted the medication cart because she was also a medication aide and administered medications to residents. She expressed feeling overwhelmed with the workload. 5. Review of the nursing staff schedule from 12/3/25 confirmed that from 2:30 p.m. to 3:00 p.m., UAP L was the only aide scheduled for resident 72's unit. CNA C was scheduled to start her shift on that unit at 3:00 p.m., and CNA N was scheduled at 4:00 p.m. 6. Review of resident 72's room call light log revealed that on 11/19/25, the bedside call light was triggered at 6:30 a.m. About 23 minutes passed until the alarm was cleared. The bedside call light was triggered again	F0550		

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F0550 SS = D	Continued from page 4 at 8:45 a.m. About 41 minutes passed until the alarm was cleared. 7. Review of resident 72's electronic medical record revealed that he was admitted to the facility for a rehabilitation stay on 11/18/25 after having back surgery. His 11/18/25 admission Brief Interview for Mental Status (BIMS) score was 11, indicating he had mild cognitive impairment. His 12/4/25 BIMS score was 13, meaning he was cognitively intact. The 11/18/25 Clinical Admission progress note indicated under the genitourinary (referring to the genital and urinary organs) section that "Resident [is] continent of bladder. Urine [is] clear yellow. Denies urinary complaints." However, the Fall Risk Evaluation completed the same day indicated that "Resident is ambulatory / incontinent." His current care plan indicated that he was dependent on staff assistance for toilet use and required "Substantial/Max assist" for transferring from surface to surface (such as from his bed to the toilet). Those interventions were created and revised on 11/20/25. Another intervention added on 11/20/25 read, "Be sure [the] resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." His wife signed the resident admission agreement on 11/18/25, indicating they received a copy of the resident's rights sheet that included details about a resident's right to dignity and respect. 8. Review of the "Family Sheets" revealed there was a list of residents for each unit. The lists contained resident information such as their name, room number, diet order, incontinence products, code status, and any assistive devices. Resident 72 was noted to have "Pull ups [incontinence briefs]" under the "PRODUCTS" column. The "Family Sheets" were last updated on 12/2/25. 9. Review of the provider's 3/18/24 Notice of Resident Rights and Responsibilities policy revealed the policy statement read, "United Living Community shall inform the resident both orally and in writing of their rights as a resident, and the rules and regulations governing the resident's conduct and responsibilities during their stay."	F0550		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)	F0554		

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F0554 SS = D	Continued from page 5 §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure two of two sampled residents (8 and 72) who had medications at their bedside were assessed for the ability to safely self-administer medications and had a physician's order to self-administer medications according to the provider's policy. Findings include: 1. Observation and interview on 12/2/25 at 10:10 a.m. with resident 8 in her room revealed she had a jar of Vick's VapoRub ointment on her overbed desk. She stated she was sick recently and she used the ointment to rub on her chest and under her nose to help her breathe. Review of resident 8's electronic medical record (EMR) revealed there was no physician's order for the use of the Vick's VapoRub. There was no evidence that a medication self-administration assessment had been completed to assess her competence and safety with using the medication by herself. Her 10/24/25 Brief Interview for Mental Status (BIMS) score was 15, meaning she was cognitively intact. Her diagnoses included weakness and rheumatoid arthritis (a disease where the body's immune system mistakenly attacks the joints, causing pain, swelling, and stiffness in the joints). 2. Observation on 12/3/25 at 9:18 a.m. in resident 72's room revealed that there was a bottle of Systane eyedrops, a bottle of saline nasal spray, and a tube of Vaseline sitting on his overbed table. Resident 72's initials were written on the bottle of Systane eyedrops. There were no pharmacy labels on any of those medications. Interview on 12/4/25 at 8:14 a.m. with resident 72 revealed that his wife brought the nasal spray and eye drops in for him shortly after he was admitted to the facility on 11/18/25. He confirmed the staff probably did not know that his wife brought those medications in for him. He kept those medications on his bedside table, so he had easy access to use them.	F0554	All residents will be assessed for Self-Administration of Medication upon Admission, and every 90 days thereafter based on the resident's MDS and Care Conference, or if there is a significant change. These assessments will be completed within the Point Click Care system, and completed by the RN Case Manager or designee. Competency based education and training will be completed for all staff that are able to administer medications, on if they see medication in a resident room without an order for self administration of medication, the medication must be removed until an order is received. Education and training will be completed by the Director of Nursing or designee. If the assessment determines a resident is capable of self administration of medication and would like to self administer, the RN Case Manager or designee will receive orders from the resident's provider and update the care plan. Audits will be completed at the ARD time by the Case Manager or designee.	1/18/2026

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F0554 SS = D	Continued from page 6 Review of resident 72's EMR revealed that there were no physician's orders for the Systane eye drops or the saline nasal spray. He had an order for the Vaseline. There was no evidence that a medication self-administration assessment had been completed to assess his competence and safety with using those medications by himself. His 12/4/25 BIMS score was 13, meaning he was cognitively intact. His care plan did not include any information about medication self-administration. 3. Interview on 12/4/25 at 1:08 p.m. with case manager G and registered nurse (RN) O revealed they were not aware of the Vick's VapoRub in resident 8's room. They confirmed there was no physician's order for resident 8 to have the Vick's VapoRub. They confirmed resident 8 had not been assessed to be able to use the ointment by herself. RN O indicated that due to resident 8's arthritis, she may have a hard time opening the jar. They were not aware of the Systane eyedrops and saline nasal spray in resident 72's room. They confirmed that resident 72 had a physician's order for the Vaseline ointment, but they were not sure if the ointment was considered a "medication" and required a self-administration assessment. Resident 72's Vaseline was ordered to be applied to his skin biopsy site every day and night shift until the site was healed. Resident 72 had not been assessed for medication self-administration for the saline nasal spray, Systane eye drops, or the Vaseline. They expected the nursing staff to pay attention to what residents were keeping at their bedsides. If someone noticed a medication in a resident's room, they expected them to tell a nurse or a manager for proper follow-up. 4. Interview on 12/4/25 at 3:31 p.m. with director of nursing B revealed that she was not aware of the Vick's VapoRub in resident 8's room, or the saline nasal spray, Vaseline, and Systane eye drops in resident 72's room. She guessed that the resident's family members brought those medications in for them. She said, "I try to discourage family from bringing medications in from home." If a resident's family did bring medications from home, the nurse would request an order from the resident's physician, request a label from the pharmacy, and assess the resident for safe medication self-administration before letting the resident store the medication in their room. 5. Review of the provider's 5/15/25 Medication	F0554	Data will be collected and aggregated and reviewed by QAPI a minimum of quarterly.	1/18/2026

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F0554 SS = D	Continued from page 7 Administration and Destruction policy revealed the policy statement read, "The purpose of this policy is to outline the guidelines for medication administration, management and destruction at United Living Community (ULC)." "Medications Received from Other Sources: …Each medication container shall be labeled with the resident's name, physician, physician assistant, or nurse practitioner's name, drug and strength, directions for use, and prescription date." "Medication Brought from Home – Can be used: -If the drug container is labeled with the resident's name, physician, physician assistant, or nurse practitioner's name, drug and strength, directions for use, and prescription date. -If the drug container is not labeled with the above, the licensed nurse must administer the medication after verifying the medication with the original medication order. -Ordered by the attending physician, physician assistant, or nurse practitioner and, if prior to administration, is identified as the prescribed medication. -The medication name, dosage form, and strength have been verified by: …Residents may not keep medications on their person or in their room without a physician's, physician assistant, or nurse practitioner's order allowing self-administration." "Self-Administration of Medication: -Residents may self-administer prescribed medications under the supervision of a licensed nurse. -A physician's order is required. -The resident must be able to demonstrate the administration of the medication and must be able to verbalize the drug name and strength and directions for use including the dose, route and time to be taken. -An evaluation and education will be documented every 90 days or upon any significant change regarding the resident's wish to self-administer from bedside or self-administer after setup will be documented." 6. Review of the provider's 6/20/24 Self-Administration of Drugs policy revealed the policy statement read,	F0554		

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F0554 SS = D	Continued from page 8 "Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so by their physician." "Policy Interpretation and Implementation: -1. As part of their overall evaluation, the practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications. -2. If the practitioner determines that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medications. -3. The staff or practitioner will ask resident who are identified as being able to self-administer medications whether they wish to do so. -4. The staff or practitioner will document if the resident is potentially capable of self-administering medications. -5. Staff shall identify and give to the Charge Nurse any medications found at the bedside of a resident who is not able to self-administer. -6. The facility will reorder medications for those who self-administer in the same manner as other medications. -7. Upon observation of a bedside medication that is expired, discontinued, or recalled, the staff will remove the medication and give it to the Charge Nurse to process. -8. Nursing staff is to record administration of medications on the medication administration record (MAR) appropriately. -9. The staff or practitioner will periodically (for example, during quarterly MDS reviews) reevaluate a resident's ability to continue to self-administer medications."	F0554		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes	F0600		

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F0600 SS = D	Continued from page 9 but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH), facility reported incident (FRI), interviews, and policy review, the provider failed to protect the resident's right to be free from neglect by certified nursing assistant (CNA) C who pivot transferred resident (28) causing her to have a fall without injuries. The resident was care planned for use of a stand lift with two staff assistance for all transfers. Findings include: 1. Review of provider's SD DOH FRI dated 11/26/25 with attached care plan for resident 28, and disciplinary action for CNA C revealed: *The report was a FRI for suspicion of abuse or neglect. *Resident 28 had a fall on 11/24/25 at 6:03 p.m. in the facility. *Her Brief Interview for Mental Status (BIMS) score as of 11/26/25 was 99 meaning an incomplete or failed interview. *Resident 28's care plan indicated: -She needed physical staff assistance with guided limb placement and cueing using a stand aid (mechanical lift used to assist from a seated to a standing position). -To not leave the [resident 28] unattended for transfers and while she was in the bathroom. *CNA C did not follow resident 28's care plan or family sheet (a paper sheet for the unit that tells pertinent information for residents) to use the stand aid for a transfer.	F0600	Reviewed the identified residents' Care Plan and family sheet to ensure it stated all transfers required 2 staff with a mechanical device. Reviewed the Mechanical Lift policy to reinforce how many staff are required to operate a mechanical lift. Re-educated all staff on mechanical lifts and who are able to operate them and who are not (scope of practice). Audit completed weekly by Director of Nursing on a transfer with a lift. Completion of training and weekly audit will be reported in QAPI to ensure all staff completed. Director of Nursing or	1/18/2026

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F0600 SS = D	Continued from page 10 *Resident 28 was not injured during the fall on 11/24/25. *CNA C was given a written warning by registered nurse (RN) H on 11/26/25 for "Resident fell due to the CNA neglectfully following the care plan, family sheet and care plan does state two [staff assistance] with stand prior to fall." 2. Interview on 12/3/25 at 3:40 p.m. with CNA D revealed: *She was working with CNA C on the memory care unit on 11/24/25 during the evening shift. *CNA C had not asked for assistance with transferring resident 28 from a stationary chair in the dining room area. *She returned to dining room area after assisting another resident and observed resident 28 on the floor and CNA C was standing next to her. *She had not observed the fall of resident 28. *Family sheets tell staff how residents are to be transferred and the type of lift to use if needed. *At the end of the staff's shift the family sheets were turned into director of nursing (DON) B. 3. Interviews on 12/3/25 at 3:49 p.m. and 4:52 p.m. with CNA C revealed: *She had worked for the provider for about two months. *She had returned to the dining room area after assisting an unidentified resident. *DA F had told her that resident 25 had assisted resident 28 from her wheelchair to the stationary chair in the dining room. *She had been assisting another resident in their room when the transfer occurred. *She had gone over and stand pivot transferred resident 28 from the stationary chair in the dining room area without a lift belt (a device placed around a person's waist used to hold onto during a transfer) back into her wheelchair.	F0600		

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F0600 SS = D	Continued from page 11 -When she pivot transferred the resident that evening resident 28's knees buckled, and CNA C lowered her to the floor. *She notified licensed practical nurse (LPN) E of that incident. *After LPN E assessed resident 28, LPN E and CNA C used a total lift (mechanical device that lifts the whole body) to assist resident 28 in her wheelchair. *The family sheets told staff how a resident was supposed to transfer and if a device such as a lift needed to be used during a transfer. *She thought the family sheet for resident 28 stated she was a two assist with stand lift for transfers. *Resident 28 had no injuries from the fall on 11/24/25. *She received a written warning disciplinary action after the incident occurred by RN H. *Based on her she was not supposed to operate mechanical lifts with the residents without other staff assistance. *She did not recall being trained and observed by another staff on the safe use of mechanical lifts. *She had asked DA F to come and stand by resident 28 during the pivot transfer in case something happened on 11/24/25. 4. Interview on 12/3/25 at 4:25 p.m. with DA F revealed: *On 11/24/25 she was training another dietary staff in the memory care unit. *She observed resident 25 pull resident 28 out of the wheelchair and had helped her stand up. *DA F went over by resident 28 and aided resident 28 to sit in a stationary chair in the dining room area. *She did not want to startle either of the residents as resident 28 was already in a standing position. *She returned to training the dietary staff after she assisted resident 28. *CNA C exited from a resident room and asked for DA F	F0600		

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F0600 SS = D	Continued from page 12 to help get resident 28 out of the stationary chair. *CNA C was already in the process of pulling and lifting resident 28 up from the chair with her hands on her waist. *DA F placed her hands above CNA C hands, resident 28 was already bent over and they lowered her to the floor. *She was hesitant to go help CNA C that day, but she did go over and help her. *CNA C had no transfer belt on resident 28. *She was unsure how residents were supposed to be transferred. *She had not completed any CNA training on how to transfer residents. 5. Interview on 12/4/25 at 10:15 a.m. with LPN E regarding resident 28's 11/24/25 incident revealed: *She had just come into work on 11/24/25 at 6:00 p.m. when she was told by a medication aide that CNA C had tried to pivot transfer resident 28 into her wheelchair. When she arrived to the memory care unit, resident 28 was sitting on the floor in the dining room. *She was unaware that DA F had been involved in the resident's transfer, DA F had left before LPN E arrived to the incident. *She was told by CNA C resident 25 had tried to pivot transfer resident 28 into the stationary chair. *Staff should have known how to transfer residents from the family sheets or the resident's care plan. *Case managers updated the family sheets every week. *She had assessed resident 28 for injuries after the incident and she had no injuries. 6. Interview on 12/4/25 at 10:28 a.m. with case manager G revealed: *Family sheets were updated with resident changes and new orders for residents and reviewed weekly.	F0600		

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F0600 SS = D	Continued from page 13 *Staff carry the family sheets the entire shift for documenting toileting, transfers and other pertinent care information for their shift. *Family sheets tell the staff how a resident is to be transferred and if a lift is to be used. 7. Interview on 12/4/25 at 2:03 p.m. with DON B revealed: *CNA C had not followed the care plan or family sheet for resident 28 to ensure a safe transfer on 11/24/25. *A written warning was completed for CNA C following the incident for that resident. *Education was provided during the above warning to CNA C. *LPN E had given CNA C education to follow care plan and that resident 28 required two staff members assistance with a stand lift for all transfers on 11/24/25. *Registered nurse (RN) H completes competencies on mechanical lifts use with staff upon hire. 8. Interview on 12/4/25 at 2:21 p.m. with RN H revealed: *CNA C had completed care plan education for residents at the time of her hire on 9/29/25. -That included the family sheets. *CNA C had competencies completed of her use of the stand lift on 9/29/25. *CNA C had completed education on the facilities of falls policy and procedures on 10/4/25. *Staff under 18 years old could not operate the mechanical lifts, but they could assist as a second staff member. *Care plans and family sheets tell staff how a resident is to be transferred. *CNA C had received a written warning from her that stated "Resident fell d/t the CNA neglectfully following the care plan. Family sheet and care plan	F0600		

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F0600 SS = D	Continued from page 14 does state 2 with stand prior to fall." 9. Review of providers revised 3/3/25 Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Policy revealed: *"It is essential for facilities to prohibit and prevent abuse. Neglect, exploitation of residents, misappropriation of resident property, corporal punishment, and involuntary seclusion, including freedom from physical or chemical restraints not required to treat a resident's medical symptoms. The facility will have systems in place to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation of residents, misappropriation of resident property, corporal punishment, and involuntary seclusion." *"Neglect: the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. -Neglect includes cases where the facility's indifference or disregard for resident care, comfort, or safety, results in or could have resulted in physical harm, pain, mental anguish, or emotional distress. -Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person."	F0600		
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	F0761		

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F0761 SS = E	Continued from page 15 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 observation, interview, record review, and policy review, the provider failed to ensure resident medications were securely stored for six of twenty-four sampled residents (8, 63, 64, 71, 72, and 73) in the South Ridge unit. Findings include: 1. Observation on 12/2/25 at 10:10 a.m. in resident 8's room revealed there was a jar of Vick's VapoRub sitting on top of her overbed desk. It was in plain view from the doorway. 2. Observation on 12/3/25 at 9:18 a.m. in resident 72's room revealed there was a bottle of Systane eyedrops, a tube of Vaseline, and a bottle of saline nasal spray sitting on his bedside table. They were in plain view from the doorway. Interview on 12/4/25 at 8:14 a.m. with resident 72 revealed that his wife brought in the Systane eye drops and the saline nasal spray to him. He confirmed the facility "probably didn't know" that his wife brought those medications in for him to use. 3. Observation on 12/3/25 at 9:26 a.m. outside of resident 71's room revealed a cabinet with a combination lock drawer. The drawer was not locked. The following medications were accessible: Albuterol inhaler solution, a tube of miconazole (an antifungal cream), a tube of diclofenac ointment (a pain reliever), a tube of triamcinolone (a corticosteroid), and a bottle of fluticasone (a corticosteroid). 4. Observation on 12/3/25 at 9:46 a.m. outside of resident 63 and 64's shared room revealed a cabinet with a combination lock drawer. The drawer was not locked. The following medications and care supplies were accessible: Albuterol inhaler, nystatin powder (an	F0761	Identified and removed any improperly labeled or improperly stored drugs and biologicals from use. Verified physician orders and pharmacy labels for affected medications. Ensured all medications were relabeled or replaced by the pharmacy prior to administration. Conducted a facility-wide audit of all medication storage areas, including medication carts, medication rooms, refrigerators, treatment rooms, and emergency kits. Identified and corrected any unlabeled, expired, improperly dated, or improperly stored drugs and biologicals. Reviewed the Medication Storage and Labeling Policy to ensure it reinforced proper labeling, storage, dating, and segregation of drugs and biologicals.	1/18/2025

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F0761 SS = E	Continued from page 16 antifungal), and a tube of Desitin cream (a zinc oxide barrier cream). 5. Observation on 12/3/25 at 9:50 a.m. outside of resident 73's room revealed a cabinet with a combination lock drawer. The drawer was not locked. The following medications were accessible: Duoneb inhaler (containing ipratropium bromide and albuterol, used to help open the lung airways), latanoprost eye drops (used to treat high blood pressure in the eyes), calcitonin salmon nasal spray (used to treat osteoporosis, a bone disease), erythromycin antibiotic, Systane eye gel, and a tube of lidocaine-prilocaine cream (a pain reliever). 6. Interview on 12/3/25 at 10:21 a.m. with licensed practical nurse (LPN) P revealed that she did not know what the policy was regarding medication storage. She was "super new here" and only worked part time. She stated that she would go ask director of nursing (DON) B if she had any questions. 7. Interview on 12/3/25 at 10:52 a.m. with registered nurse (RN) Q revealed that she expected the resident's medication cabinets and drawers to be locked. Medications like inhalers, eye drops, ointments, and creams were stored in the resident's medication cabinets and drawers. The medication cabinets and drawers were to be locked and inaccessible to unauthorized persons at all times. The combination lock code for residents' medication cabinets was the same throughout the facility. 8. Observation on 12/3/25 at 1:51 p.m. in resident 8's room revealed a locked cabinet hanging on her wall. The cabinet was locked, but the key to unlock it was hanging on a screw to the left side of the cabinet. The cabinet and key were in plain view from the hallway. The cabinet was able to be unlocked and opened with that key. The following medications were in resident 8's cabinet: a Humalog insulin pen, two Troujeo Solostar insulin pens, Desitin cream, fluticasone, a Symbicort inhaler, an Albuterol inhaler, Diclofenac gel, and a Duoneb inhaler. 9. Interview on 12/4/25 at 11:54 a.m. with LPN R revealed that she expected the resident's medication cabinets and drawers to be locked at all times and inaccessible to unauthorized persons. 10. Interview on 12/4/25 at 1:08 p.m. with case manager G and RN O revealed they were not aware of the	F0761	Re-educated licensed nursing staff on medication labeling and storage requirements, including manufacturer instructions and pharmacy labeling standards.The Director of Nursing or designee will conduct weekly audits of medication storage areas for 4 weeks, then monthly thereafter. Audit results will be documented and reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified issues will be addressed immediately with staff re-education and	1/18/2026

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F0761 SS = E	Continued from page 17 medications at residents 8 and 72's bedsides. They expected any resident medication to be securely locked for safety and to prevent access by unauthorized persons. If a staff noticed medications sitting out in a resident's room, they expected staff to notify a nurse or a manager to ensure the medications were stored safely. They expected the resident's medication cabinets and drawers to be locked at all times. 11. Interview on 12/4/25 at 3:31 p.m. with DON B revealed she expected that all medications should have been locked up to prevent unauthorized persons from accessing the resident's medications. She was not aware of the unlocked medication cabinets and drawers on the South Ridge unit. She tried to discourage family from bringing in medications from the resident's home. If the resident or family wanted to bring in medications from home, she would have expected the nurse to obtain a physician's order and ask the pharmacy for a pharmacy label. 12. Review of the provider's 5/15/25 Medication Administration and Destruction policy revealed the policy statement read, "The purpose of this policy is to outline the guidelines for medication administration, management and destruction at United Living Community (ULC)." "Medications Received from Other Sources: …Each medication container shall be labeled with the resident's name, physician, physician assistant, or nurse practitioner's name, drug and strength, directions for use, and prescription date." "Medications Brought from Home – Can be used: …Residents may not keep medications on their person or in their room without a physician's, physician assistant, or nurse practitioner's order allowing self-administration." "Medication Storage: All medications will be stored in a locked medication cart or in a locked medication room. …Separate storage of topical medications and oral medications…"	F0761		
F0803 SS = E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must-	F0803		

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F0803 SS = E	Continued from page 18 §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to follow the planned menu for the pureed diet, which had the potential to affect all residents who were prescribed the pureed diet, for two of two meals observed, and failed to follow the planned menu for all diet types for one of two meals observed which had the potential to affect all residents. Findings include: 1. Observation on 12/2/25 at 10:59 a.m. in the memory care unit dining room revealed the posted menu listed pulled pork sandwiches, potato salad, V8 juice (a brand of tomato juice), and pistachio dessert. Dietary aide (DA) S did not serve pureed potato salad to the residents on a pureed diet, as the kitchen did not send any pureed potato salad. Those residents were not offered an alternative to the potato salad. Instead, DA S only served them the pureed sandwich, V8 juice, and pureed dessert. 2. Observation on 12/2/25 at 11:20 a.m. in the Robins View dining room revealed the posted menu was the same	F0803	Reviewed the identified residents' diet orders, nutritional assessments, and care plans. Ensured meals served met prescribed diets, caloric requirements, and texture modifications. Consulted with the Registered Dietitian (RD) to implement appropriate nutritional interventions and monitoring. Conducted a facility-wide review of resident diet orders and corresponding menus. Verified menus were prepared in advance, approved by the Registered Dietitian, and aligned with residents' nutritional needs. Corrected any discrepancies between planned menus and meals served and ensured staff awareness. Reviewed and revised the Menu Planning and Meal Service Policy to reinforce advance menu preparation, RD approval, and adherence to posted menus. Re-educated dietary and nursing staff on following approved menus, honoring therapeutic diets, and documenting substitutions.	1/18/2026

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F0803 SS = E	Continued from page 19 as listed above for the memory care unit. DA T did not serve the potato salad, instead offering either a fruit cup or pasta salad to the residents. Residents who were on a pureed diet were not offered an alternative to the potato salad. 3. Interview on 12/2/25 at 3:50 p.m. with dietary manager I revealed that they ran out of potato salad for lunch because their food supplier did not deliver enough. She thought that the residents received coleslaw, rather than the pasta salad that was served as a substitute, instead of potato salad. 4. Interview on 12/4/25 at 10:04 a.m. with cook U revealed that they did not receive enough potato salad from the food supplier to serve to the residents on 12/2/25. They used the pasta salad as a substitute. She did not puree the potato salad for the residents who were on a pureed diet that day because she wanted to save as much potato salad for the regular diets as possible. She said the residents on the pureed diet received V8 juice instead of the potato salad. She did not realize the V8 juice was on the regular menu and that the residents who were on a pureed diet were supposed to have a nutritionally similar substitute when they ran out of the potato salad. She confirmed the residents on a pureed diet did not receive an alternative food option during the noon meal on 12/2/25. She said that "we make sure they have 3 items. They had the meat, the dessert, and the juice." She confirmed the residents on a pureed diet were not served a complete meal for lunch on 12/2/25 as compared to what other residents received and as compared to the written menu. She informed the dietary manager about the potato salad shortage after lunch on 12/2/25, not before. She did not record the menu substitution anywhere. There used to be a menu substitution log that was kept in the kitchen office, but she could not find it anymore. 5. Observation on 12/4/25 from 10:48 a.m. to 11:23 a.m. in the South Ridge dining room revealed the posted menu included country fried steak, mashed potatoes, country gravy, "Cali blend veggies" (cooked broccoli, cauliflower, and carrots), and tropical fruit. The menu diet extension binder (a detailed menu of what each therapeutic diet was supposed to receive, including serving size amounts) indicated that the menu for lunch was supposed to include a 2-to-3-ounce (oz.) country fried steak, a half cup of mashed potatoes, a quarter cup of country gravy, a half cup of California	F0803	Implemented a standardized menu substitution log requiring RD review. The Dietary Manager or designee will conduct weekly meal observations and menu audits for 4 weeks, then monthly thereafter. Audits will verify menus are prepared in advance, RD-approved, and followed as planned. Results will be reported to the QAPI Committee, with corrective actions taken as indicated.	1/18/2026

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F0803 SS = E	Continued from page 20 blend vegetables, a 2-inch by 2-inch piece of cake, and a dinner roll with margarine. The menu posted on the wall did not include dinner rolls, but the menu extension binder did include dinner rolls. The menu posted on the wall included tropical fruit instead of cake, but the menu extension binder included the cake instead of tropical fruit. The tropical fruit was included in that night's supper menu instead. There were no dinner rolls available or served. The cake was served rather than the tropical fruit as posted on the dining room menu. Residents on the pureed diet were to receive a "#8" scoop (about a half cup) of pureed vegetables, but dietary aide K only served them a quarter cup of pureed vegetables. 6. Interview on 12/4/25 at 11:23 a.m. with DA K revealed that she knew she was supposed to have served a half cup of the pureed vegetables. The only resident on that unit that received a pureed diet was resident 49, and she knew that the resident did not have a big appetite, so she only served her a quarter cup of vegetables instead of a half cup. DA K confirmed she was not aware that the menu extension binder indicated that dinner rolls were supposed to have been served with lunch. The kitchen did not send any dinner rolls. 7. Interview on 12/4/25 at 11:35 a.m. with cooks J and U revealed that neither of them were aware that dinner rolls were supposed to have been served for lunch that day. They confirmed that dinner rolls were included in the menu extension binder located in the kitchen. Cook J was not aware of what that binder was. 8. Interview on 12/4/25 at 1:46 p.m. with DM I revealed that she expected the cooks not to substitute a menu item unless they ran out of that food. She expected staff to contact her for approval of the substitute food item prior to serving the food. She confirmed there was no menu substitution log, so there was nothing for the registered dietitian to review to ensure the substitution was appropriate. She confirmed that the cooks should have prepared a pureed substitution when they ran out of the potato salad. She was not aware that the posted menu on the wall in the dining room did not match the menu extension binders. She was not aware that a dinner roll	F0803		

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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
F0803 SS = E	Continued from page 21 was supposed to have been served that day for lunch. Their food supplier did not always contact them beforehand to inform them of food supply issues, nor did they provide a reasonable alternative. She was able to make food order substitutions if their supplier informed her of shortages ahead of time. 9. Review of the provider's 4/11/24 Substitutions policy revealed the policy statement read, "Food substitutions will be made as appropriate or necessary." "1. The food services manager, in conjunction with the clinical dietitian, may make food substitutions as appropriate or necessary. The food services shift supervisor on duty will make substitutions only when unavoidable." "2. The food services manager will maintain an exchange list identifying the seven (7) exchanges of food groups. When in doubt about an appropriate substitution, the food services manager will consult with the dietitian prior to making the substitution." "3. Residents' likes and dislikes will be considered when making substitutions." "4. All substitutions are noted on the menu and filed in accordance with established dietary policies. Notations of substitutions must include the reason for substitution." "5. The food services manager will review the substitutions regularly to avoid recurrences when possible."	F0803		
F0806 SS = D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;	F0806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435079	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED LIVING COMMUNITY	405 FIRST AVE , BROOKINGS, South Dakota, 57006

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F0806 SS = D	Continued from page 22 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the provider failed to serve appropriate gluten-free foods to one of one sampled resident (70) who was on a gluten-free diet for one of two meals observed. Findings include: 1. Observation on 12/4/25 from 10:48 a.m. to 11:23 a.m. in the South Ridge dining room revealed the menu extension binder (a detailed menu of what each therapeutic diet was supposed to receive, including serving size amounts) indicated that the gluten-free diet was supposed to receive a plain hamburger, a half cup of gluten-free mashed potatoes, a quarter cup of gluten-free gravy, a half cup of California vegetable blend (cooked broccoli, cauliflower, and carrots), a gluten-free dessert (the menu did not specify what kind of dessert), and a gluten-free bun. Dietary aide (DA) K served resident 70 the regular menu which consisted of a country fried steak, mashed potatoes with country gravy, and cooked vegetables. He received two gluten-free Rice Krispie treats. Resident 70 ate the country fried steak, mashed potatoes, and country gravy. 2. Interview on 12/4/25 at 11:23 a.m. with DA K revealed she knew resident 70 was supposed to receive a gluten-free diet. The cooks in the kitchen were responsible for making and sending the gluten-free foods, but they did not send the gluten-free alternatives for that meal. She mentioned that resident 70 has been known to eat gluten-containing foods before. For example, at breakfast that day, he was served his gluten-free pancakes, but he requested to eat the biscuits and gravy instead. She did not ask him, the nurse, or the resident's representative if it was okay to serve him the regular gluten-containing meal for lunch. 3. Review of resident 70's electronic care record revealed that a gluten-free diet with regular textures and regular consistency was ordered on 11/25/25, which was the day he admitted to the facility. 4. Interview on 12/4/25 at 11:26 a.m. with resident 70's daughter revealed that she confirmed he had celiac disease (an autoimmune disorder that causes the immune system to attack the intestines when a person eats gluten) and ulcerative colitis (a condition where the colon is inflamed and ulcers form). He sometimes chose	F0806	Reviewed the identified residents' medical records, dietary assessments, and care plans for documented food allergies and preferences. Ensured dietary cards, meal tickets, and kitchen production sheets accurately reflected resident allergies and preferences. Provided appropriate meal substitutions as needed to meet resident safety, nutritional needs, and stated preferences. Notified nursing, dietary staff, and the Registered Dietitian (RD) of required allergy precautions. Conducted a facility-wide review of all residents' documented food allergies, preferences, and diet orders. Verified accuracy of dietary cards. Corrected any discrepancies and ensured allergy alerts were clearly visible in dietary and nursing systems. Reviewed and revised the Allergy Management and Meal Substitution Policy to reinforce identification, documentation, and communication of resident allergies and preferences. Re-educated dietary and nursing staff on allergy awareness, honoring resident preferences, and providing appropriate substitutions.	1/18/2026

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F0806 SS = D	Continued from page 23 to eat gluten-containing foods. She did not know if he experienced negative reactions when he ate gluten. She would have preferred if the gluten-free diet was offered to him with each meal. 5. Interview on 12/4/25 at 11:32 a.m. with cook U revealed that she was aware that resident 70 was supposed to receive a gluten-free diet. She was not the main cook that day. She expressed frustration with having to remind the other cooks about following his gluten-free diet. 6. Observation on 12/4/25 at 11:34 a.m. in the kitchen revealed the nutrition facts labels for the country fried steak and the country gravy included wheat, which contains gluten. There were packages of gluten-free gravy mix available in the dry storage room. 7. Interview on 12/4/25 at 11:35 a.m. with cook J revealed that she was aware that resident 70 was supposed to receive the gluten-free diet. She did not make any of the gluten-free menu items that day because she "totally spaced [it]." There was a laminated list of resident dislikes/allergies taped on the prep table across from the ovens, but resident 70 was not on that list. She did not know how often that list was updated. Resident 70 was the only resident on a gluten-free diet. 8. Interview on 12/4/25 at 1:46 p.m. with dietary manager I revealed that she was aware that resident 70 was supposed to receive the gluten-free diet. She "did her best" at trying to update the list of resident dislikes/allergies each time a new resident was admitted, or when a resident told her their likes or dislikes. She could not remember the last time she updated that list for the staff to reference. She expected her staff to follow the planned menu for each diet.	F0806	Implemented a standardized process for documenting and approving meal substitutions, including RD oversight when indicated. The Dietary Manager or designee will conduct weekly audits of meal trays, dietary cards, and substitution logs for 4 weeks, then monthly thereafter. Audits will verify resident allergies and preferences are honored and substitutions are appropriate and documented. Results will be reported to the QAPI Committee, and corrective actions will be implemented as needed.	1/18/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from	F0812		

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F0812 SS = F	Continued from page 24 local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the provider failed to maintain the kitchen floor and windowsill in the dish room in a clean and sanitary manner in one of one main kitchen. Findings include: 1. Observation on 12/2/25 from 8:17 a.m. to 8:41 a.m. during the initial kitchen tour in the main kitchen revealed the floor underneath the rubber mats in the dish room was caked with a brown and black substance. The rest of the tile floor in the kitchen was gray in color and appeared to be clean. The rubber mats in the dish room were the standard slip-resistant black rubber mats with drainage holes in it. The windowsill in the dish room was visibly dusty, with scattered food crumbs, dead flies, and mosquitoes. A large, white, fluffy seed, resembling a dandelion seed, was also present on the surface. Interview on 12/2/25 at 8:23 a.m. with cook U revealed that the dish room rubber mats were usually cleaned monthly in the warmer months. They would take the mats outside to pressure wash them. They could not do that now that it was below freezing temperatures outside. She could not remember the last time those mats were moved out of the way to clean the floor underneath. She was usually scheduled as a baker rather than as a cook. The cooks had a weekly and monthly cleaning checklist. The floors were supposed to be mopped daily. Once the cleaning checklists were filled out, they gave them to dietary manager (DM) I. 2. Observation and interview on 12/4/25 at 9:57 a.m. in	F0812	Immediately addressed identified sanitation concerns in the kitchen, including cleaning and sanitizing affected areas, equipment, and utensils. Conducted a facility-wide inspection of all kitchen, food storage, and service areas. Cleaned and sanitized all food contact surfaces, equipment, and high-touch areas. Reviewed and revised the Kitchen Sanitation and Food Service Policy to reinforce cleaning schedules, approved sanitizers, and safe food handling practices. Re-educated dietary staff on infection control principles, cleaning and sanitizing procedures, and sanitary food service. Implemented a documented daily and weekly kitchen cleaning checklist. Ensured adequate supplies of approved cleaning agents, PPE, and hand hygiene products. The Dietary Manager or designee will complete daily sanitation audits and weekly supervisory inspections for 4 weeks, then monthly thereafter. Findings will be documented and reviewed by the QAPI Committee. Any identified deficiencies will be corrected immediately with staff re-education or disciplinary action as appropriate.	1/18/2026

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F0812 SS = F	Continued from page 25 the dish room with cook J revealed that the floor beneath the rubber mats and the windowsill were in the same state as described above. Cook J did not know when the windowsills were last cleaned and agreed that it looked dirty. She said, "the bugs are gross." When she helped clean the kitchen daily, she mopped the floors, but she did not move the rubber mats out of the way to clean the floor beneath them. She would mop around the rubber mats. 3. Interview on 12/4/25 at 1:46 p.m. with DM I revealed that she was aware the floors were stained. She said, "We have an issue in this kitchen." The maintenance department has a "big machine" that they were supposed to clean the floors with once a month, but that machine was broken. She expected staff to sweep and mop the floors daily, and to clean the rubber mats once a month. When asked if those tasks were documented, she explained that the monthly cleaning checklists included cleaning the rubber mats. She was not aware of the dirty windowsill. She did not know if that should be cleaned by the kitchen or maintenance staff. She confirmed the kitchen cleaning checklists did not include cleaning the windowsills. Review of the monthly cleaning checklists at that time with DM I revealed that the rubber mats in the dish room had not been documented as cleaned since June 2025, six months prior.	F0812	Reviewed the identified residents' medical records for immunization status, physician orders, and consent or refusal documentation. Obtained physician orders as needed and offered influenza and/or pneumococcal vaccines to eligible residents. Administered immunizations per protocol or documented resident/legal representative refusal. Updated medical records to accurately reflect immunization status. Conducted a facility-wide audit of all resident records to verify influenza and pneumococcal immunization status. Identified residents who were eligible and ensured vaccines were offered, administered, or refusals appropriately documented. Reviewed the Immunization Policy to ensure it reinforced assessment, consent, administration, and documentation requirements. Re-educated nursing staff on immunization protocols, resident education, and documentation standards. Implemented a standardized immunization tracking tool to monitor vaccine status for all residents.	1/18/2026
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F0883		

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F0883 SS = D	Continued from page 26 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure four of four sampled residents' (1, 4, 28, and 30) right to immunize against pneumococcal disease was maintained and followed in accordance with national standards of practice. Failure to offer vaccination placed residents at increased risk for pneumococcal disease.	F0883	Ensured standing physician orders are maintained for seasonal influenza and pneumococcal vaccines. The Infection Preventionist or designee will review immunization tracking logs monthly. Compliance data will be reported to the QAPI Committee. Any missed or delayed immunizations will be addressed promptly with corrective action and staff re-education as needed.	1/18/2026

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F0883 SS = D	Continued from page 27 Findings include: 1. Record review of resident 1's electronic medical record (EMR) revealed he last had a pneumococcal vaccine on 1/8/20. The documentation did not indicate what exact vaccine he was administered. He did not have a documented allergy to the pneumococcal vaccine. He did not have a documented signed refusal document for the pneumococcal vaccine. He was admitted to the facility on 10/8/18. 2. Record review of resident 30's EMR revealed no documentation that the resident received or had been offered and declined a pneumococcal vaccine. He did not have a documented allergy to the pneumococcal vaccine. He did not have a documented signed refusal for the pneumococcal vaccine. He was admitted to the facility on 8/16/24. 3. Record review of resident 28's EMR revealed no documentation that the resident received or had been offered and declined a pneumococcal vaccine. She did not have a documented allergy to the pneumococcal vaccine. She did not have a documented signed refusal for the pneumococcal vaccine. She was admitted on 8/9/22. 4. Record review of resident 4's EMR revealed she had a pneumococcal vaccine on 5/5/2008 recorded as dose 1. She received Prevnar 13 (vaccine that protected against 13 types of bacteria) on 8/28/2017. She did not have a documented allergy to the pneumococcal vaccine. She did not have a documented signed refusal for the pneumococcal vaccine.	F0883		

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F0883 SS = D	Continued from page 28 She was admitted on 1/31/24. 5. Interview on 12/4/25 at 2:52 p.m. with registered nurse (RN) H revealed she was the full-time infection preventionist (IP) at the facility. She indicated when a resident was admitted to the facility, the resident and their family member received a document called a "Why note." The "Why note" provided information on the vaccinations that were offered by the facility and the importance as to why the resident should receive those vaccines such as the pneumococcal vaccine. She indicated that her procedure to monitor the residents' vaccinations were correlated with their scheduled medical provider appointments. She stated that some mid-level providers would not order resident immunizations, as there were some medical doctors who wanted to be the provider who placed those orders for the residents. She stated that she would look at the list of scheduled provider appointments and then look at the resident's immunizations that were documented in their EMR. She indicated she also utilized the South Dakota immunizations web site for verification of residents' vaccinations. She stated if she found that a resident was not up to date with their immunizations, she relayed that information to their medical provider so it could be addressed at the resident's appointment. She indicated that the pharmacist who monitored the resident's medications also helped monitor the resident's immunizations, such as the pneumococcal vaccination. She indicated that the facility found that the previous IP did not document correctly in the resident's EMR or on the South Dakota immunization website to specify what pneumococcal vaccine the residents received. She confirmed the above resident's pneumococcal vaccination records and documentation was a concern. She confirmed there should be documentation in the residents' EMR if the resident declined the vaccine. She confirmed the national standards for the different types of pneumococcal vaccinations and different	F0883		

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F0883 SS = D	Continued from page 29 recommendations based on vaccination and the resident's age, diagnoses, or any other factors. She stated the facility did not have a performance improvement project (PIP) in place but were aware of the problem. 6. Review of the provider's Resident Vaccination Policy dated 3/31/25 revealed: "Policy Statement" "It is the policy of United Living Community (ULC) to follow the recommendations of the Centers from Disease Control and Prevent (CDC) and the Advisory Committee on Immunization Practices (ACIP) from resident vaccination unless medically contraindicated, resident is already immunized, or the resident declines after the provision of education on risks and benefits or through shared decision making with their medical provider." "Procedure" "All new residents will be screened and offered vaccines for influenza, pneumococcal disease and COVID-19 unless specifically ordered otherwise by the Primary Provider on admission orders" -"CMS does not require physician orders for influenza, pneumococcal, and COVID-19 vaccinations." -"Provider orders are required for other vaccinations. Consider obtaining standing orders for other vaccinations." -"Every resident upon admission is screened using the criteria contained in each vaccine section below." -"Education on the risks of each vaccine in the form of Vaccination Information Statements (VIS) statements will be offered prior to vaccination administration." -"Licensed nursing staff performs the screening and vaccine administration." "The resident or the resident's representative has the opportunity to refuse any immunization." "Pneumococcal Immunization Program" "Each new resident will be assessed and identified for	F0883		

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F0883 SS = D	Continued from page 30 the need to receive pneumococcal vaccine using the CDC's Pneumococcal Vaccine Timing for Adults." "May use CDC's PneumoRecs VaxAdvisor to assist with evaluating of a resident's pneumococcal status."	F0883		

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness requirements for Long Term Care Facilities, was conducted on 12/2/25. United Living Community was found in compliance.	E0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Liz DeBerg	Administrator	12.22.2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435079	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/02/2025

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 12/2/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. United Living Community was found in compliance.	K0000		

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
Liz DeBerg	Administrator	12.22.2025

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10601	A. BUILDING: _____ B. WING _____	12/04/2025

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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) COMPLETE DATE
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/2/25 through 12/4/25. United Living Community was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Liz DeBerg

TITLE: Administrator

(X6) DATE: 12.22.202