PRINTED: 06/03/2026
FORM APPROVED
OMB NO. 0938-0391

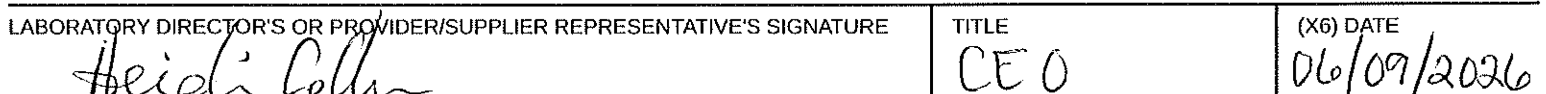
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A103	A. BUILDING B. WING	**05/27/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadoka Nursing Home	**605 MAPLE ST W POST OFFICE BOX 310, KADOKA, South Dakota, 57543**

(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 on 5/27/26. Areas surveyed included resident safety related to an elopement and fall prevention interventions. Kadoka Nursing Home was found not in compliance with the following requirement: F657.	F0000	The care plan for resident 1 has been updated to reflect elopement risk and interventions in place to decrease risk/diversion of elopement on 5/27/2026. An updated elopement assessment will be completed on resident 1. An updated elopement assessment will be completed on all residents. Care plans will be updated for all residents that trigger as a risk for elopement. Elopement assessments will be completed and/or reveiwed upon admission, quarterly, and with a significant change. The Director of Nursing or Designee will audit 3 random care plans weekly of individualization and accuracy for 10 weeks and report to quality assurance process improvement monthly for 3 months.	06/13/2026
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.	F0657		

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
Heidi Coll[illegible]	CEO	06/09/2026

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F0657 SS = D	Continued from page 1 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 review and revise one of one sampled resident's (1) care plan (personalized plan that addresses a resident's care needs, goals, and interventions) after the resident eloped (left the facility without staff knowledge). Findings include: 1. Review of the provider's 3/9/26 SD DOH FRI revealed that on 3/8/26 at 2:10 p.m., resident 1 opened the front entrance door of the facility causing the door's alarm to sound. Certified nurse aide (CNA) F responded to the alarm. She saw the front door closing behind resident 1. CNA F redirected the resident back inside the facility and settled her back into her room. At 2:30 p.m. that same afternoon, the door alarm sounded again. CNA G responded to the alarm. He found resident 1 standing in front of the open front door entrance. The resident wanted to "go away for a while." She was redirected away from the front entrance by CNA G. 2. Review of the provider's 3/22/26 SD DOH FRI revealed that on 3/21/26 at 9:32 p.m., the door alarm sounded. Registered nurse (RN) H and CNA I checked the facility's doors, which were all closed. An internal search of the facility revealed that resident 1 was unaccounted for. She was not found inside the facility or on the facility's grounds. Her family member and law enforcement were notified of the resident's absence. Resident 1 was last seen in her bed by the staff. At 9:38 p.m., en route to the facility, resident 1's family member saw resident 1 lying on the ground approximately 30 yards away from the facility. After resident 1 returned to the facility, she was assessed by the nursing staff for any injuries. Resident 1 had a small hematoma (collection of blood under the skin caused by injury) below the crown of her head. Neurological checks (assessment of nerve function, reflexes, coordination, motor skills, sensation, and mental status) were initiated. They were within normal limits. Resident 1's physician was notified of her elopement and injury. 3. Review of resident 1's electronic medical record (EMR) revealed she admitted to the facility on 1/11/22. Her diagnoses included dementia (a group of symptoms affecting memory, thinking, and social	F0657		

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F0657 SS = D	Continued from page 2 abilities) with agitation, irritability, and depression. Her 4/26/26 Brief Interview for Mental Status (BIMS) assessment score was 8, which indicated her cognition was moderately impaired. Resident 1 received psychiatric services. A 5/5/26 psychiatric progress note indicated that resident 1 had moments of delusion (false beliefs and distorted view of reality) and agitation. "[Resident 1] believes she can go home and live independently." "She has poor safety awareness and is at risk for falling." The resident was prescribed Seroquel (an anti-psychotic) and Zoloft (an antidepressant). There were no recent changes to those medications. The resident's initial 2/2/22 Elopement Risk Assessment score was 17, which indicated that resident 1 was a high risk for eloping related to her cognitive impairment, poor decision-making, her desire to leave the facility, and her ability to ambulate. Her 4/28/26 Elopement Risk Assessment indicated that the resident remained a high risk for eloping. Her 4/24/26 Wandering Risk Scale assessment score was 13. An assessment score of 11 or higher indicated a resident was at high risk for wandering. Resident 1's 4/28/26 through 5/26/26 Wandering UDA (user-defined assessment) revealed she wandered 18 of those 30 days. Resident 1's revised 5/27/26 care plan did not mention her wandering, exit-seeking (a behavior in persons with dementia, characterized by attempts to leave a secure area of a facility), or eloping. 4. Interview on 5/27/26 at 1:35 p.m. with laundry staff J revealed she had worked at the facility for about three years. She knew resident 1 sometimes forgot to use her walker when she walked, and stated she wanted to "go home," and would walk towards the front door. She was verbally redirected by the staff when that happened. 5. Interview on 5/27/26 at 1:40 p.m. with CNA K revealed she had worked at the facility for about four years. She knew resident 1 was confused and would pack a bag because she had a "baby boy at home." At those times, the resident might walk towards the front entrance as if to leave the facility. She was monitored closely by the staff. Resident 1 usually responded to reassurance from the staff when she was told that "the boy was fine." The resident also wandered into other residents' rooms. At times, the staff had resident 1 talk with a family	F0657		

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F0657 SS = D	Continued from page 3 member on the phone to calm her. The resident's family members also came to the facility to support the resident. CNA K knew all the door entrances would alarm if they were opened by someone other than an employee. There were cameras positioned at the facility entrances, and a television monitor by the nurses' station showed views of those entrances. 6. Observation and interview on 5/27/26 at 1:30 p.m. with resident 1 revealed that she sat in a chair near the nurses' station with her walker in front of her. She was neatly dressed, smiling, and calm. She felt fine, but she had a corn on her right foot. 7. Observation on 5/27/26 at 3:20 p.m. revealed resident 1 was in an activity room seated next to another resident. Two young family members were playing nearby. At 3:30 p.m., resident 1 approached administrator A and asked her about going out "to the rodeo" that day. Resident 1 accepted administrator A's explanation that it was too hot to be outside that day, and the rodeo may be over. Resident 1 commented that she "had been up working since 8:00 a.m. that day anyway." 8. Interview on 5/27/26 at 1:45 p.m. with Minimum Data Set (MDS) Nurse D revealed she worked one day per week at the facility. She completed residents' MDS assessments, updated resident care plans, and attended resident care conferences. MDS Nurse D acknowledged that resident 1's care plan did not address her wandering, exit-seeking, or elopement risk, even though she knew resident 1 demonstrated those behaviors. 8. Interviews on 5/27/26 at 2:20 p.m. and 3:00 p.m. with administrator A revealed that all staff were made aware of the above FRIs regarding resident 1 after those incidents occurred. They were reminded how wandering and exit-seeking behaviors, and elopements were expected to be managed. On 4/28/26, the facility conducted a mock elopement drill. Administrator A stated that high winds the night of resident 1's 3/21/26 elopement may have awakened her, causing her to get out of bed and leave her room. The resident was also being treated for a urinary tract infection, which may have increased her confusion at that time. The facility's door alarm sounded properly when it was opened by resident 1, the staff responded to	F0657		

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F0657 SS = D	Continued from page 4 that alarm as they were expected to, and reacted properly when resident 1 was not able to be accounted for. 9. Interview on 5/27/26 at 3:30 p.m. with administrator A, MDS Nurse D, director of nursing (DON) B, assistant DON C, and RN/social services director (SSD) E revealed resident 1's sundowning (increased confusion, anxiety, agitation that peaks in the late afternoon or early evening) correlated with her wandering and exit-seeking behaviors. The resident was more inclined to wander and exit-seek after she returned from outings with her daughter, when she showed signs and symptoms of a potential urinary tract infection, when she verbalized a desire to "go home," and when she packed a bag to "go home." Interventions that were implemented when resident 1 wandered and sought out facility exits included staff supervision, limiting the resident's off-grounds outings, verbal redirection, family phone calls or visits, anticipating the resident's needs for thirst, hunger, continence care, or physical exercise, and individualized diversion activities for the resident to engage in. The above staff acknowledged that all of the above information related to resident 1 should have been in her care plan. Administrator A, DON B, ADON C, and RN/SSD E, in addition to MDS Nurse D, were also responsible for ensuring that resident 1's care plan was revised to reflect her individualized needs. 10. Review of the provider's revised 4/11/26 Elopement of a Resident policy revealed that following a resident elopement, "The care plan should be updated with additional approaches being implemented."	F0657		