STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435066	A. BUILDING B. WING	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA PRINCE OF PEACE	4513 SOUTH PRINCE OF PEACE PLACE , SIOUX FALLS, South Dakota, 57103

(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
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 9/22/26. Avera Prince of Peace was found in compliance.	E0000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrick Berry	Director-Nursing Home Administrator	10/16/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10722	A. BUILDING: _____ B. WING _____	09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA PRINCE OF PEACE	4513 PRINCE OF PEACE PLACE SIOUX FALLS, SD 57103

(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 9/22/26 through 9/24/26. Avera Prince of Peace was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patrick Berry
TITLE: Director-Nursing Home Administrator
(X6) DATE: 10/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA PRINCE OF PEACE	4513 SOUTH PRINCE OF PEACE PLACE , SIOUX FALLS, South Dakota, 57103

(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
K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 9/22/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avera Prince of Peace (Building 01) was found in compliance.	K0000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrick Berry	Director-Nursing Home Administrator	10/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435066	A. BUILDING **02 - BUILDING 0...** B. WING	**09/22/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA PRINCE OF PEACE	**4513 SOUTH PRINCE OF PEACE PLACE , SIOUX FALLS, South Dakota, 57103**

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K0000 Bldg. 02	INITIAL COMMENTS A recertification survey was conducted on 9/22/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avera Prince of Peace (Building 02) was found in compliance.	K0000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrick Berry	Director-Nursing Home Administrator	10/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435066	A. BUILDING **03 - BUILDING 3** B. WING	**09/22/2026**

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AVERA PRINCE OF PEACE	**4513 SOUTH PRINCE OF PEACE PLACE , SIOUX FALLS, South Dakota, 57103**

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K0000 Bldg. 03	INITIAL COMMENTS A recertification survey was conducted on 9/22/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avera Prince of Peace (Building 03) was found in compliance.	K0000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrick Berry	Director-Nursing Home Administrator	10/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA PRINCE OF PEACE	**4513 SOUTH PRINCE OF PEACE PLACE , SIOUX FALLS, South Dakota, 57103**

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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 9/22/26 through 9/24/26. Avera Prince of Peace was found not in compliance with the following requirements: F552, F657, F688, F732, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/22/26 through 9/24/26. Areas surveyed included potential resident abuse and neglect and resident safety related to the provider's grievance process, the use of a lift chair, and behavior management with security support systems, and quality of nursing care and treatment related to bathing, wound care, and pain management, missing resident personal items, and potential inappropriate resident discharges from the facility. Avera Prince of Peace was found to have past non-compliance at F689.	F0000		
F0689 SS = G	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, and interview, the provider failed to ensure an environment free of safety hazards for one of one sampled resident (138) who fell out of a lift chair (an electric armchair with a built-in motor that tilts the	F0689	"Past Noncompliance - no plan of correction required"	11/08/2026

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Patrick Berry	Director-Nursing Home Administrator	10/20/202 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2026

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F0689 SS = G	Continued from page 1 entire seat forward and upward to help a person safely transition from a sitting to a standing position) and injured her left first metacarpal (the thumb's palm bone between the wrist and thumb knuckle). This citation is considered past non-compliance based on a review of the provider's corrective actions immediately following the incident. Findings include: 1. Review of the provider's 12/10/25 SD DOH FRI revealed that on 12/10/25 at 2:30 p.m., the nursing staff found resident 138 in her room on the floor in front of her lift chair after she attempted to get up from the chair without staff assistance. A nurse assessment revealed that resident 138's vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) were within normal ranges, and she did not complain of any pain. Later that evening, resident 138 complained of nausea and increased pain in her back and legs. She was transferred to the emergency room and admitted to the hospital due to sepsis (a life-threatening medical emergency that occurs when the immune system overreacts to an infection and damages the body's organs) from a urinary tract infection (UTI, a bacterial infection that affects any part of the urinary system, including the bladder, urethra, or kidneys). Imaging tests indicated that she had a possible fracture to her left first metacarpal. She returned to the facility at a later date. 2. Review of resident 138's electronic medical record (EMR) revealed she admitted to the facility on 12/23/22. Her 12/9/25 Brief Interview for Mental Status (BIMS) assessment score was 11, which indicated her cognition was moderately impaired. She had diagnoses of type 2 diabetes mellitus (a condition involving disruptions in how the body regulates blood sugar), depression (a common and serious mental disorder that causes persistent feelings of sadness, emptiness, and a loss of interest or pleasure in daily activities), anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), atrial fibrillation (an irregular and often very rapid heart rhythm disorder affecting the heart's upper chambers), and peripheral vascular disease (a medical disorder where blood vessels outside the heart narrow, block, or spasm, most commonly reducing blood flow to the legs and feet).	F0689		11/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2026

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F0689 SS = G	Continued from page 2 Her 12/9/25 Fall Risk Assessment indicated she had a high risk for falling. Her 12/9/25 care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) indicated two staff members were to assist her with a total body lift (a mechanical lift and sling used to lift a person's full body) for all transfers. She had a history of refusing some medications and attempts by the staff to reposition her throughout the day. Her 12/9/25 care plan indicated her lift chair should have been unplugged as a result of her Lift Chair Assessments on 6/23/25, 9/8/25, and 12/9/25, which all determined she was unsafe to operate the chair independently. 3. Interview and EMR review on 9/24/26 at 9:54 a.m. with director of nursing (DON) B regarding resident 138's incident revealed that earlier in the day on 12/10/25, resident 138 had used her call light but had refused repositioning attempts from the staff. DON B stated that when she interviewed the nursing staff about the incident on 12/12/25, they recalled that resident 138's lift chair was unplugged before her fall, and they were unsure when or how it was plugged in and became operational. Following resident 138's fall on 12/10/25, DON B and assistant director of nursing (ADON) C removed the power cord from resident 138's lift chair so it could no longer be plugged in. They updated her care plan to reflect that her lift chair was no longer operable. They evaluated all residents who used a lift chair, and for residents determined unsafe to use the lift chairs independently, they removed the power cord from the chairs so they could not be plugged in. The provider's lift chair assessment and policy were updated to include removing the power cord from a lift chair for residents determined unsafe to operate the chair independently. Residents were to be assessed for lift chair safety upon their admission to the facility and with each of the residents' Minimum Data Set (MDS) assessments (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs). All nursing staff were educated on the lift chair	F0689		11/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2026

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F0689 SS = G	Continued from page 3 assessment and policy updates during daily shift meetings from 12/15/25 through 12/23/25. New staff members were to review the updated policy as part of the employee onboarding process. Each resident's lift chair safety status was reflected in their care plan and on the daily task lists referenced by certified nursing assistants (CNAs). DON B and ADON C reviewed resident 138's EMR and did not find any missed signs of the resident having a potential UTI, such as a fever, complaints of pain, increased incontinence (involuntary loss of bladder control or leaking urine), odors, or increased urination. They determined that her desire to self-transfer out of the lift chair on 12/10/25 was unusual and likely a result of her increased confusion caused by her UTI. Nurse supervisors audited each of the facility's units weekly from 12/15/25 through 1/15/26 to ensure that the lift chair power cords were removed on all lift chairs for residents determined unsafe to operate them independently. They audited the CNA's daily task lists to ensure that each resident's lift chair safety assessment outcome was included on the CNA's daily task list. The facility's investigation, updated lift chair assessment and policy, and audit findings were reviewed at the provider's Quality Assurance and Performance Improvement (QAPI) Committee meeting in January 2026 to analyze findings and discuss further action with the facility's medical director and other members of the QAPI Committee. 4. Interview on 9/24/26 at 10:21 a.m. with CNA M revealed that the staff did not leave residents who were considered unsafe to operate a lift chair alone in their rooms. Instead, the residents were to be brought to the nurse's station or the television lounge area to be monitored. She said the staff sometimes relied on a wheelchair or chair sensor pad that sounded an alarm if the resident tried to get out of their chair. 5. Interview on 9/24/26 at 10:51 a.m. with licensed practical nurse (LPN) P revealed that after the nurses assess residents for lift chair use, they entered the resident's safety status into their EMR, where it could be seen on the daily task lists that CNAs referenced while providing resident care. The nurses	F0689		11/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2026

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F0689 SS = G	Continued from page 4 also communicated the resident's safety status during meetings at shift change. 6. Based on the above information, non-compliance at F689 occurred on 12/10/25, and based on the provider's 12/15/25 implemented corrective actions for the deficient practice confirmed on 9/24/26, the non-compliance is considered past non-compliance.	F0689		
F0688 SS = E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure an ongoing restorative nursing program was implemented for three of four sampled residents (7, 44, and 117) identified as at risk for declining range of motion (ROM). Findings include: 1. Observation and interview on 9/22/26 at 10:44 a.m. with resident 44 in her room revealed that she was seated in a custom wheelchair, and her left arm rested in her lap with her hand in a fist. She wore a grey boot on her left lower leg from her knee to her toes. She stated that she was unable to move her left arm and leg since she had a stroke over 10 years ago.	F0688	**Corrective Action for Affected Residents** The RN Coordinator, or designee, will complete a restorative nursing reassessment for Residents 7, 44, and 117 by 10/23/26. The assessments will take into consideration any recommendations from recent skilled therapy discharges. Their care plans will be updated to include individualized ROM, strength, mobility, transfer, contracture-prevention, and functional-maintenance interventions, as indicated by the assessment. This will also be completed by 10/23/26. **Identification of Other Residents Potentially Affected** An audit will be completed of 100% of residents with ROM limitations, mobility impairment, recent therapy discharge, restorative services, or MDS coding indicating ROM limitations. The audit will verify active restorative programming, documentation, physician orders if applicable, and care plan integration. The RN Coordinator, or designee, will be completed by October 30th, 2026. **Systemic Changes** A restorative nursing policy will be developed and implemented by November 8th. A standardized Therapy-to-Restorative Handoff process will be created and implemented by November 8th, 2026. A restorative nursing checklist will be created and implemented to help ensure all aspects of the program are in place at initiation of the program by November 8th, 2026. A care plan meeting checklist will be created to aid RN Coordinators to ensure residents have been assessed for Restorative Nursing programs, if indicated by resident condition or resident request and that the program is care planned. This checklist will be created by November 8th, 2026. Education will be provided to licensed nurses, CNAs, MDS personnel, and therapy staff on restorative identification, implementation, documentation, and monitoring at all staff in-services between 10/26/26 and 10/30/26 by the RN Supervisor, or designee. **Monitoring Plan** The Director of Nursing, or designee, will audit 5 residents with documented limitations in range of motion weekly for 8 weeks to verify they have a restorative nursing care plan and that they are receiving those services, if indicated. Results of the audits will be reported to the facility QAPI committee by the DON, or designee, for further direction related to frequency of audits and reporting.	11/08/2026

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F0688 SS = E	Continued from page 5 She stated that she used to be able to open the fingers on her left hand with her right hand but could no longer do so. She stated that the staff did not assist her with ROM exercises for her arm or leg and that her left arm and leg felt stiff and "awful sore" when she woke up in the morning, but she tried to "go with the flow." She stated that she used a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position to transfer from her recliner and bed into her wheelchair, and the only time that her left leg exercised was when the staff lifted her foot on and off the wheelchair's footrest. She occasionally attended a group exercise class each day at 11:15 a.m. in the living room, but she could only participate with her right arm and leg. She thought she used to do more exercises with her left arm and leg but could not recall what they were. 2. Review of resident 44's electronic medical record (EMR) revealed she admitted to the facility on 1/21/16. She had a diagnosis of cerebral vascular accident (stroke). Her 9/15/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her care plan (personalized plan that addresses a resident's care needs, goals, and interventions) included a focus area that indicated the resident had pain related to her hemiplegia (the total or partial paralysis on one side of the body, affecting the arm, leg, and often the face) and osteoporosis (a disease that causes bones to become weak, thin, and brittle) and a goal that "I [the resident]will maintain an acceptable level of pain." Interventions included "offer non-pharmacological [not pain medication] pain management interventions." Which non-pharmacological interventions were to be provided was not specified. She had a goal that "I will maintain my same level of ADL [activities of daily living] Function throughout my next review." There were no documented interventions that included to provide her ROM exercises or a restorative program to maintain her ADL function. Her most recent quarterly 9/15/26 Minimum Data Set (MDS) assessment (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) indicated she had a functional limitation in ROM in one lower extremity (hips, knees, ankles, and feet) and one upper extremity (shoulders,	F0688		11/08/2026

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F0688 SS = E	Continued from page 6 elbows, wrists, and hands), and she did not receive restorative nursing exercise programs. 3. Observation and interview on 9/22/26 at 11:18 a.m. with resident 7 in her room revealed she was seated in a power tilt-in-space wheelchair (a specialty wheelchair that tilts the entire seat and backrest backward as a single unit). She felt she was not receiving the exercises she needed to maintain her strength or ROM, and she was getting weaker. She received occupational therapy and physical therapy at times, but when her “days were used up,” she was discharged from those therapies, and no other staff members at the facility assisted her with exercises or ROM for her arms and legs. She did not think there was anywhere to exercise besides the daily activities group exercise class held in the living room. She did not attend those group exercise classes because it was difficult for her to exercise in her wheelchair. She wanted to ride the Nu Step exercise bike but did not think the staff had time to help her use it. She recalled that the long-term care facility where her parents lived provided a restorative therapy program. She did not think that a program like that was available to her at this facility because she was provided occupational and physical therapy, and the number of days she could receive those services was limited. She wanted to maintain her hand strength and dexterity because she completed self-catheterizations (a procedure you perform on yourself to empty your bladder by inserting a thin, flexible tube called a catheter through your urethra) several times each day. 4. Review of resident 7's EMR revealed she admitted to the facility on 4/2/25. She had a diagnosis of multiple sclerosis (MS, a chronic, unpredictable disease of the central nervous system that disrupts communication between the brain and the body). Her 7/21/26 BIMS assessment score was 15, which indicated her cognition was intact. Her care plan included a focus area that indicated the resident had pain in her left knee, hip, and low back at times and that she had MS. The goal was that “I [the resident] will maintain an acceptable level of pain.” Interventions included “offer non-pharmacological pain management interventions.” Which non-pharmacological interventions were to be provided was not specified.	F0688		11/08/2026

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F0688 SS = E	Continued from page 7 She had a goal “to maintain my strength and independence throughout my next review date.” The documented interventions did not include exercises or a restorative program to maintain her strength or ADL function. He 8/15/26 quarterly MDS assessment indicated she had a functional limitation in ROM in both lower and both upper extremities, and she did not receive restorative nursing exercise programs. 5. Observation on 9/22/26 at 11:43 a.m. with resident 117 in the dining room revealed that he was seated in a wheelchair at the dining room table and had swelling in his left lower leg. He used his left hand to support his right hand while cutting his food and feeding himself. During lunch, his wheelchair moved away from the table several times, and he dropped food on his lap. 6. Review of resident 117’s EMR revealed he admitted to the facility on 2/2/26. He had diagnoses of lumbar spondylosis with myelopathy (age-related wear and tear in the lower back causes bone spurs or disc changes that compress the spinal cord), physical deconditioning, and weakness. His 7/28/26 BIMS assessment score was 3, which indicated his cognition was severely impaired. His 7/28/26 quarterly MDS assessment indicated he had a functional limitation in ROM in one lower extremity, and he did not receive restorative nursing exercise programs. His 3/4/26 physical therapy discharge summary indicated that a restorative program was established. That restorative program included ambulation (walking) and a range-of-motion program. His 3/6/26 “OT [occupational therapy] Restorative Nursing Program” indicated that he was to complete a dressing program, ambulate to the bathroom for toileting, and complete specific upper extremity exercises with an exercise band and “reaching up” motions with each arm. His 3/6/26 “PT [physical therapy] Restorative Nursing Program” indicated he was to complete seated leg exercises and ride the Nu Step exercise bike three times per week. His 5/18/26 care plan included goals to “maintain my current mobility level throughout my next review” and “I will maintain my same level of ADL Function throughout my next review.” The documented interventions did not include exercises or a restorative program to maintain his strength,	F0688		11/08/2026

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F0688 SS = E	Continued from page 8 mobility, or ADL function. 7. Interview and documentation review on 9/23/26 at 12:08 p.m. with assistant director of nursing (ADON) C revealed that she provided a list of eight residents who received restorative nursing programs. Resident 7, resident 44, and resident 117 were not on that list. She expected that if occupational therapy or physical therapy recommended that a resident was to receive a restorative nursing program, the resident would be offered that program. Registered nurse (RN) coordinator D was responsible for ensuring that residents 7, 44, and 117 were assessed for their need for a restorative program. 8. Interview and review of resident 117's EMR on 9/24/26 at 8:31 a.m. with RN coordinator D revealed that resident 117 needed setup assistance at mealtime. She was not aware that he had difficulty feeding himself his lunch on 9/22/26. RN coordinator D confirmed that resident 117's ROM in his left lower leg had decreased due to edema (swelling). She stated that she spoke with resident 117's family member at his last care conference about having resident 117 walk more frequently. RN coordinator D thought the staff offered to walk with resident 117, but they did not document when they walked with him, how far he walked, or if he refused to walk in his EMR. She did not think that resident 117 had a restorative program; however, when she reviewed his EMR, she discovered that when resident 117 was discharged from therapy in March 2026, a restorative program was established. At that time, resident 117 resided in the Rehab neighborhood and then moved to his current room in another area of the facility. She thought that with resident 117's room change and a recent change in the provider's EMR system, that resident 117's restorative program was not being completed or documented by staff members. She confirmed that resident 117 was not offered his restorative program since he moved to his current room in April 2026. 9. Interview and review of resident 44's EMR on 9/24/26 at 8:43 a.m. with registered nurse RN coordinator D revealed that resident 44 had limited ROM of her left side, but she was unsure if resident 44's left hand was contracted (a permanent or severe tightening of muscles, tendons, skin, and nearby tissues that causes joints to shorten and become stiff). She thought the activities staff offered	F0688		11/08/2026

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F0688 SS = E	Continued from page 9 resident 44 group exercise classes up to five times a week. RN coordinator D was unsure how often resident 44 participated in those group exercise classes. RN coordinator D confirmed that resident 44 could not move her left arm or left leg independently and that the group exercise class did not include exercises to move resident 44's left arm or left leg. She did not expect the certified nursing assistants (CNAs) to complete ROM exercises with resident 44. She thought that if resident 44 wanted to do exercises with her left arm and left leg, she would have asked a staff member about it, and that staff member would have notified RN coordinator D. RN coordinator D then would have asked the therapy department to evaluate resident 44 for a ROM program. Occupational therapist (OT) E began working with resident 44 on 9/22/26, when resident 44 received a new custom wheelchair. RN coordinator D wondered whether OT E completed ROM exercises with resident 44. RN coordinator D confirmed there were no documented interventions to address resident 44's limited ROM in her left arm and leg, or to prevent contracture development. 10. Interview and review of resident 7's EMR on 9/24/26 at 9:19 a.m. with RN coordinator D revealed she was not aware that resident 7 wanted to ride the Nu Step exercise bike. Resident 7 was discharged from occupational therapy on 6/22/26, and RN coordinator D was unsure whether occupational therapy had assessed resident 7's ability to ride the Nu Step or her need for a restorative program. RN coordinator D confirmed no interventions were in place to address resident 7's limited ROM or strengthening needs. RN coordinator D expected the CNAs to notify the nurse if any residents, including residents 7, 44, and 117, had any decline in their mobility or ability to get dressed so she could obtain a physician's orders for a therapy evaluation. She confirmed no preventative interventions were in place and no restorative programs were established for resident 7 or resident 44, who needed assistance with ROM or exercises to maintain their highest level of function, and that resident 117 was not offered since his room change in April 2026. 11. Interview and record review on 9/24/26 at 10:33 a.m. with OT E revealed he did not assess resident 44's ROM or her need for exercises or a restorative program. OT E's 9/22/26 occupational therapy	F0688		11/08/2026

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F0688 SS = E	Continued from page 10 evaluation focused on resident 44's custom wheelchair. He was unsure if resident 44 received restorative or ROM exercises. He thought resident 44 might benefit from a restorative nursing program to maintain, improve, or prevent an avoidable decline in her ROM and mobility, but he did not know whether she received those services. OT E did not treat resident 7 when she received her power tilt-in-space wheelchair. OT E reviewed resident 7's therapy documentation and stated that the physical therapy evaluation and discharge notes were focused on her use of the power wheelchair and did not address her need for a restorative exercise program or her ability to ride the Nu Step exercise bike. He did not know if resident 7 would have benefitted from a restorative program because he did not assess her. OT E recalled working with resident 117 when he resided in the Rehab neighborhood and confirmed that an OT and PT restorative program was recommended when he was discharged from those therapy services in March 2026. He expected that resident 117 would be offered those restorative programs. 12. Review of the provider's 10/1/25 Facility Assessment revealed "The services and care provided assist people to reach their highest level of practicable potential and maintain their ability to participate in life activities if they are able." Staff Competencies for RNs. Licensed practical nurses (LPNs) and CNAs included "Range of Motion - Lower Extremity" and "Range of Motion - Upper Extremity." 13. A policy related to the provider's restorative nursing program was requested on 9/23/26 at 2:01 p.m. and again on 9/24/26 at 12:33 p.m. from administrator A, but was not received before the survey exit.	F0688		
F0812 SS = E	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	F0812	**Corrective Action for Residents/Areas Affected** The flattop grill, one convection oven, and two floor drains in the main kitchen along with a kitchenette refrigerator/ freezer and hot food cart in the Arrowhead Trail and Boulder Creek neighborhoods were thoroughly cleaned. Food items in the reach-in cooler and alternative meal refrigerator were also checked for labeling, and discarded if not labeled or if found to be after the use-by-date.	11/08/2026

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F0812 SS = E	Continued from page 11 authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed standard food safety and sanitation practices regarding: One of one flattop grill, one of four convection ovens, and two of several floor drains in the main kitchen, one of four kitchenette refrigerator/freezer, and one of several hot food carts that were not maintained in a clean manner; Food items were not labeled and dated in a reach-in cooler and the alternative meal refrigerator in the main kitchen; Food items had not been discarded on or before the use-by date according to the provider's policy. Findings include: 1. Observation on 9/22/26 from 8:34 a.m. to 9:02 a.m. in the main kitchen revealed that there was a reach-in cooler with several doors located underneath the windows that faced the café area. Inside the cooler, several containers of food were not labeled or dated, including banana peppers, shredded cheese, diced tomatoes, sliced cucumbers, and diced red and green peppers. There was a container of white onion slices with a date of 9/10 written on it. There was a container of deli meat that was not labeled with what type of meat it was, and had the date 9/16 written on it. In the back of the cooler, there was half of a red onion wrapped in plastic cling wrap. That onion had a date of 7/29 written on it, and the onion had partially turned	F0812	**Identification of Other Residents/Areas at Risk** All areas were checked for cleanliness and thoroughly cleaned if determined to be unsanitary. All food items were also checked to ensure they were accurately labeled with a use-by-date and discarded when expired. **Systemic Changes** The cleaning sheet was updated to include sanitation of the noted areas. A new door was ordered on 10/13/2026 to replace the glass door of the Southbend G-Series convection oven. All Dietary employees will received education on the cleaning sheet along with dating and discarding of food items the week of October 26th by the RN Supervisor or designee. **Monitoring** The cleaning sheet will be audited 3x per week for 12 weeks by the Support Service Manager or designee along with a visual inspection of the cleaning areas. The fridges will also be audited 3x per week for 12 weeks by the Support Services Manager or designee to ensure food items have a use-by-date and expired items have been purged timely. Results will be shared by the Support Service Manager or designee with the monthly QAPI committee for review and direction.	11/08/2026

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F0812 SS = E	Continued from page 12 black with rot. The floor drain under the two-compartment sink, located underneath the spice shelf, was covered in a black, red, and green discolored grime. There was also a large quantity of cooked noodles in the drain. The grease trap drawer under the flattop grill had a large buildup of food and grease around the drawer and was difficult to open. The grease was dripping from the drawer, and another drip pan was placed on the floor to catch the excess grease. There was a buildup of dust between the glass panels of one of the Southbend G-Series convection ovens, that was consistent with it having a broken or malfunctioning seal. In the refrigerator labeled “alternative meal fridge,” there was a container of canned peaches that was labeled “9/9/26 to 9/12/26,” a container of mandarin oranges labeled “9/10/26,” a container of chocolate pudding labeled “9/8,” and another container of a pureed substance labeled “pumpkin bar 9/15.” 2. Observation and interview on 9/24/26 at 7:34 a.m. with dietary server H in the Boulder Creek and Arrowhead Trail kitchenette revealed several areas of dried red juice spilled in the refrigerator on multiple surfaces, including in the produce drawers. A red, sticky substance was present in the lower freezer rubber gasket. The freezer had thick ice buildup on the left side that had dripped and refrozen, as evidenced by what appeared to be icicles. Dietary server H stated she was aware of the juice spills and was responsible for cleaning the refrigerator. She tried to clean the refrigerator once a week, but did not document when she cleaned it, and thought she cleaned it last week. She was aware that there was an ice buildup in the freezer. She was not responsible for defrosting the freezer. She was unsure who was responsible for defrosting the freezer and when that was last completed. The heated food cart, used to transport the residents’ food from the main kitchen to the Boulder Creek and Arrowhead Trail kitchenette, had brown dripping stains on the back and a white film buildup on the back where the vents were located. The door had a significant amount of brown and yellow buildup, and food crumbs were on the outside bumper. Dietary server H stated that she thought the kitchen staff cleaned the heated food carts. 3. Observation and interview on 9/24/26 at 8:55	F0812		11/08/2026

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F0812 SS = E	Continued from page 13 a.m. in the dish room with dietary server Y revealed there was a significant buildup of an unidentified black substance in the floor drain under the dishwasher, on the floors and walls under the dishwasher, on the caulking sealant behind the water sprayer and garbage disposal, and in the corner of the wall to the right of the dishwasher. There was a sign posted on the dish room door that included a list of cleaning tasks. The “PM Shift Expectations” dated 4/3/26 included, "Dish [room] floors must be sprayed down every night, including underneath counters and around the drains,” “The Bleach Germicidal Cleaner needs to be poured down the drains on the floor under the 3-compartment sink and silver counters. Spray down with [the] hose after,” “Use Dawn Platinum Spray to clean the stainless-steel surfaces underneath the counters,” “The shelf under the dirty side of the dish room needs to be cleaned as well and no standing water left.” Dietary server Y stated that the evening dietary staff were responsible for cleaning the floors and walls in the dishroom at the end of each evening shift. He said that the dietary department has a power washer that was used to spray down the dishroom floors. 4. Interview on 9/24/26 at 9:05 a.m. with cook X revealed that the evening dietary staff were responsible for deep cleaning the flattop grill and the grease trap drawer. She was aware that the flattop grill was leaking grease. She did not know how long that was happening or why it was dripping. 5. Interview on 9/24/26 at 9:21 a.m. with lead cook W revealed that he was aware that the flattop grill was leaking grease. He said that the staff cleaned it “every once and awhile.” Someone came to the facility to try to fix it before, but that did not work. Regarding food storage and labeling, the facility had recently implemented a new rule that prepared food items were supposed to be labeled and could be kept for three days. After three days, the food was to be discarded. 6. Interview on 9/24/26 at 10:27 a.m. with certified dietary manager (CDM) support services manager V revealed that the food items in the reach-in cooler were supposed to be labeled and dated once prepared. Regarding the food items, such as diced tomatoes, she expected the staff to write the prepared date on the container, and the food was supposed to be discarded after three days. The three-day rule was implemented within the past	F0812		11/08/2026

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F0812 SS = E	Continued from page 14 couple of months. She confirmed that the staff were trained on those new expectations. The dietary staff were responsible for cleaning the floors and floor drains at the end of the day, and the maintenance department used a floor cleaning machine once per week. The staff were to mop the floors every night. She expected the staff to clean the walls in the dish room about once per month. She stated that some of the floor drains should be cleaned more often than what the staff were currently doing. She was “working on” a new cleaning checklist for the kitchen. She did not know how often the floor drains were currently cleaned. She was aware that the flattop grill was leaking grease. A contracted foodservice equipment company came to work on it twice before, but that did not fix the issue. She did not know when that contracted foodservice equipment company was last at the facility to address the issue. She explained that the leaking grease was a potential fire hazard, as there was an open flame to heat the flattop grill. She was not aware that there was a buildup of dust between the glass panels of one of the convection ovens. She mentioned that the maintenance department staff knew how to take that machine apart to clean it. She confirmed that the dietary staff were responsible for keeping the neighborhood kitchenettes clean including the counters, the fridge, and the freezer. The heated food carts were supposed to be wiped down after each scheduled shift, and the evening staff were supposed to remove, clean, and replace the trays inside the food carts at the end of their scheduled shift. 7. Review of the provider’s September 2026 Kitchen Cleaning Sheet revealed that all task items were scribbled out from September 1st to September 23rd. Items on the task list included “AM Cook – Cooks fridge, outdated food thrown, spills cleaned up,” “TC Cook – Clean/Sanitize under counters,” “PM Cook – Shelf [in between] counters cleaned/everything put back and sanitized,” “Baker – Fridge outside dishroom (outdated food thrown).” 8. Review of the provider’s September 2026 PM Closing Task Sheet revealed that the task list was assigned by the neighborhoods the staff were scheduled to work in. There were instructions on the bottom of the page that read, “This needs to be	F0812		11/08/2026

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F0812 SS = E	Continued from page 15 completed [every night] by [the] neighborhood that is assigned to the task. No one can leave until the tasks assigned to 'everyone' are completed and [the] PM cook confirms tasks are done. Initial once complete." The staff person assigned to the Oakwood assisted living center was supposed to mop and spray down the dishroom floor. That task was marked as completed on 9/1, 9/3, 9/5, 9/6, 9/9, 9/10, 9/12, 9/13, 9/18, and 9/20. "Everyone" was assigned to clean the inside and outside of the red boxes (the heated food carts). That task was marked as completed every day except for on 9/1, 9/2, 9/15, 9/17, 9/19, and 9/22. The staff person assigned to the "1st floor" was responsible for cleaning the countertops in the dishroom. That task was marked as completed on 9/5, 9/6, 9/9 through 9/14, 9/18, and 9/20. The staff person assigned to the "TCU" was responsible for polishing the stainless steel in the dishroom. That task was marked as completed on 9/1 through 9/6, 9/9, 9/12, 9/13, 9/18, and 9/20. Neither the Kitchen Cleaning Sheet nor the PM Closing Task Sheet included instructions for the staff to clean the convection ovens or the flattop grill. 9. Review of the provider's June 2026 Food Safety and Sanitation LTC (Long Term Care) Division Policy revealed that there were eight pages in the policy. Pages two and three were missing from the copy of the policy given to the survey team. Under the section titled "Food Preparation and Service," "Food is served as soon as possible. Leftover food is treated as recommended by Food Service Code. All leftover food is discarded after 3 days (72 [hours]). All perishable food items are labeled and dated prior to refrigeration or freezing." Under the section titled "Equipment," "Ovens and oven racks in the kitchen are cleaned thoroughly once a month, and/or after spills occur." "The floor well drain is cleaned weekly and as needed." "Stove top and grill are cleaned after each meal." "Cleaning schedules are posted & include frequency, position responsible and signed off when completed."	F0812		11/08/2026

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F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must	F0880	**Corrective Action** LPN Q was provided re-education on 10/15/26 related to hand hygiene, Enhanced Barrier Precautions, catheter care, enteral feeding care, and medication administration. **Identify Other Residents Potentially Affected** Infection Preventionist will increase frequency of environmental rounds to weekly on each area beginning 10/19/26 through November 8th, 2026. These rounds will include medication passes, catheter care, feeding tube care, wound care, and Enhanced Barrier Precaution use across all neighborhoods. Re-education of staff will take place at the time of the round. **Systemic Changes** A formal infection prevention environmental rounds process and form will be developed by 10/30/26. The environmental rounds process will include observation of random medication passes, residents requiring tube feeding, if applicable, catheter care, wound care, and enhanced barrier precautions. It will also include immediate, documented coaching of any deficiencies in practice found during the round. The process will include documented next actions and a mechanism for reporting results to facility leadership and the POP QAPI committee. All staff will be educated on infection prevention practices related to medication passes, catheter care, feeding tube care, wound care, enhanced barrier precaution use, and hand hygiene at all staff in-services between 10/26/26 and 10/30/26 by the RN Supervisor, or designee. **Monitoring** The Director of Nursing, or designee, will conduct 10 observations each of hand hygiene, PPE compliance, Enhanced Barrier Precautions, catheter care, enteral feeding care, and medication administration practices weekly for 8 weeks. The audits, along with results from environmental rounds, will be reported by the DON, or designee, to the QAPI committee who will also implement focused corrective actions, as needed.	11/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2026

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F0880 SS = E	Continued from page 17 prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed infection prevention and control practices by one of one licensed practical nurse (LPN) (Q) who failed to use personal protective equipment (PPE) while providing care for one of three sampled residents (40) on Enhanced Barrier Precautions (gown and glove use when providing high contact care) (EBP) related to a gastronomy-tube (flexible tubing placed through the abdominal wall into the stomach to deliver nutrition, fluids, and medications) and urinary catheter (flexible tubing inserted into the bladder to drain urine); and failed to perform hand hygiene (using soap and water or an alcohol based hand sanitizer to wash hands) during four of nine sampled residents' (3, 14, 28, and 40) medication administrations. Findings include: 1. Observation on 9/23/26 at 8:31 a.m. showed a sign on resident 40's room door reading, "EBP," meaning staff were to wear PPE while performing high-contact care with this resident. Inside the room, LPN Q was observed wearing a pair of gloves but not a gown. She administered prune juice to resident 40 through his gastronomy-tube (G-tube). She then flushed the G-tube (a process where clean	F0880		11/08/2026

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F0880 SS = E	Continued from page 18 water is pushed from a syringe into the tube to prevent clogging and provide hydration) and, without changing her gloves, performing hand hygiene, or putting on a gown, she opened a suction kit to clear resident 40's airway of fluids. She used her soiled left gloved hand to adjust the left sleeve of her sweatshirt, turn on the suction machine, and raise the head of the resident's bed so he was sitting up straighter. After suctioning fluid from resident 40's throat, she turned the suction machine off, then discarded the suction tubing and her soiled gloves in the resident's trash can. Without performing hand hygiene, putting on clean gloves, or putting on a gown, she swabbed resident 40's mouth with a small sponge, discarded the sponge into the trash can, and opened the blinds on the window. Resident 40 asked LPN Q to change the gauze around his catheter tubing. She could not find any gloves in resident 40's room, and changed the catheter gauze without performing hand hygiene, wearing gloves, or wearing a gown. At 8:53 a.m., LPN Q left resident 40's room without performing hand hygiene and pushed a computer on a portable stand down the hallway to resident 3's room. Using her bare, unclean hands, she entered resident 3's room with her computer, unlocked resident 3's in-room medicine cupboard, and retrieved an alcohol wipe and two insulin pens. Without performing hand hygiene, she put on a pair of gloves, lifted resident 3's shirt, and used the alcohol wipe to clean resident 3's abdomen (stomach area). She then injected the resident with 35 units of insulin Glargine (a long-acting insulin used to control blood sugar levels) and 18 units of insulin Aspart (a fast-acting insulin used to control high blood sugar). She discarded the alcohol wipe in resident 3's trash can, put the insulin pens back in the medicine cupboard, and locked it. With those same gloved hands, she moved resident 3's tray table next to her bed and then typed on the computer. She removed and discarded her soiled gloves in resident 3's trash can, performed hand hygiene with hand sanitizer, and pushed the portable computer out of resident 3's room to the nurse's station, where she picked up a glucometer (a small, portable device used to measure the amount of sugar (glucose) in a small sample of blood) and placed it on a docking station that sent blood sugar readings to the residents' EMRs. At 9:05 a.m., LPN Q left the nurse's station and pushed the portable computer into resident 14's room. Without performing hand hygiene, she	F0880		11/08/2026

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F0880 SS = E	Continued from page 19 unlocked resident 14's medicine cupboard with her bare hands, removed a nebulizer (a device that converts liquid medication into an inhalable mist) kit, and measured 2 milliliters (mL) of Budesonide (a medication used to reduce inflammation in the lungs). With her bare, unclean hands, she put the nebulizer mask on resident 14 and turned on the nebulizer machine. She returned to the medicine cupboard and removed two insulin pens, then placed them on the computer stand. LPN Q stated that she was unable to find resident 14's morning blood sugar reading in the EMR. She left the room and carried the two insulin pens to the nurse's station. She picked up the glucometer, searched through its stored data, and placed it back on the dock, without locating resident 14's blood sugar reading. She walked down the hallway to certified nursing assistant (CNA) O and asked if she recalled resident 14's blood sugar reading. CNA O stated she did not remember what the reading was. LPN Q walked to a different nurse's station, picked up a second glucometer, searched through the readings, and replaced it on the dock, still unable to find resident 14's blood sugar reading. She informed CNA N that neither glucometer was sending blood sugar readings to the residents' EMRs. LPN Q returned to resident 14's room, and without performing hand hygiene, she put the insulin pens back in his medicine cupboard, unhooked his nebulizer, rinsed the mask and tube in the bathroom sink, placed the nebulizer equipment in the medicine cupboard, and locked it. She then left resident 14's room without performing hand hygiene. She pushed her portable computer to the nurse's station, picked up the telephone, called registered nurse (RN) clinical support supervisor (CSS) U, and told her about the broken glucometers. At 9:20 a.m., LPN Q pushed her portable computer into resident 28's room. Without performing hand hygiene, she used her bare hands to unlock resident 28's medicine cupboard and search for an insulin pen. When she could not locate it, she locked the medicine cupboard, walked across the hallway, opened the door to the nurse's medication room. She retrieved an insulin pen and returned to resident 28's room. Without performing hand hygiene, she used the portable computer to verify resident 28's insulin order in her EMR and put on a pair of gloves. She administered 15 milligrams (mg) of Tirzepatide Mounjaro (a medication used to improve blood sugar	F0880		11/08/2026

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F0880 SS = E	Continued from page 20 control), discarded the insulin pen in a sharps container (a puncture-resistant plastic box used to safely store used medical needles), removed her soiled gloves, and discarded them in resident 28's trash can. She applied hand sanitizer to her hands and performed hand hygiene as she left resident 28's room with her portable computer. She crossed the hallway to the nurse's station, where RN CSS U had fixed the glucometers and told LPN Q that resident 14's blood sugar reading was now in his EMR. At 9:28 a.m., LPN Q located resident 14 at a table in the dining room, preparing to eat breakfast. She asked if she could take him to his room to give him insulin. He agreed, and she wheeled him into his room. She unlocked his medicine cupboard and removed the two insulin pens and an alcohol wipe. Without performing hand hygiene, she put on a pair of gloves and used the alcohol wipe to clean an area on resident 14's abdomen. She then administered the resident 30 units of insulin NPH (an intermediate-acting medication used to control blood sugar) and 22 units of insulin Aspart (a fast-acting insulin used to control high blood sugar). She put the insulin pens back in the medication cupboard, locked it, removed and discarded her soiled gloves, and without performing hand hygiene, wheeled resident 14 back to the dining table. He asked for a glass of milk, which she picked up from the serving counter with her soiled hands and set it on the table in front of him. She returned to resident 14's room to retrieve the portable computer, took it to the nurse's station, and proceeded to document on the computer, without performing hand hygiene. 2. Review of resident 40's EMR revealed he admitted to the facility on 11/5/09. His 8/24/26 Brief Interview for Mental Status (BIMS) score was 15, which indicated his cognition was intact. He had a suprapubic catheter (a flexible tube placed through a small lower abdominal incision directly into the bladder to drain urine when regular urination is not possible). He had diagnoses of major depressive disorder (a mental health condition characterized by a persistent low mood or loss of interest in activities lasting at least two weeks), anxiety (a mental health condition involving persistent, excessive fear or worry that interferes with daily life), other specified disorder of the bladder (a bladder condition characterized by a sudden, strong need to urinate often throughout the day and night, an inability to completely empty the bladder, and a feeling of pressure, aching, or pain in the lower abdominal or	F0880		11/08/2026

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F0880 SS = E	Continued from page 21 pelvic region), and spastic quadriplegic cerebral palsy (a severe form of cerebral palsy affecting a person's ability to move and maintain balance and posture, characterized by extreme muscle stiffness and lack of motor control affecting all four limbs, the trunk, and the face). Review of resident 3's EMR revealed she admitted to the facility on 3/14/23. Her 9/8/26 BIMS score was 15, which indicated her cognition was intact. She had diagnoses of type 2 diabetes mellitus (a chronic medical condition when a person's body resists insulin or does not produce enough of it, causing sugar to build up in the blood). Review of resident 14's EMR revealed he admitted to the facility on 4/4/24. His 7/1/26 BIMS score was 9, which indicated his cognition was moderately impaired. He had diagnoses of type 2 diabetes mellitus with long-term use of insulin (a chronic medical condition when a person's body resists insulin or does not produce enough of it, causing sugar to build up in the blood), chronic obstructive pulmonary disease (a long-term lung condition that blocks airflow and makes it hard to breathe), and chronic respiratory failure (a long-term condition where the respiratory system cannot properly move oxygen into the blood or remove carbon dioxide from it). Review of resident 28's EMR revealed she admitted to the facility on 8/15/23. Her 8/4/26 BIMS score was 9, which indicated her cognition was moderately impaired. She had a diagnosis of type 2 diabetes mellitus (a chronic medical condition when a person's body resists insulin or does not produce enough of it, causing sugar to build up in the blood). 3. Interview on 9/23/26 at 4:19 p.m. with LPN Q revealed she should have worn a gown and gloves while providing care for resident 40, and that she should have performed hand hygiene before administering medication to residents 3, 14, and 28; after removing her soiled gloves; before putting on a new pair of gloves; and before she exited each resident's room. 4. Interview on 9/24/26 at 8:28 a.m. with registered nurse(RN)/infection preventionist (IP) R revealed she trained LPN Q on hand hygiene, EBP, and transmission-based precautions (extra infection	F0880		11/08/2026

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F0880 SS = E	Continued from page 22 control steps used along with standard precautions for patients known or suspected to be infected with specific transmissible pathogens) when she was hired. She expected the staff to perform hand hygiene when they entered a resident's room, before and after using PPE such as gowns and gloves, when switching care tasks such as exiting a resident's room or transitioning from providing catheter cares to medication administration, and when their hands were visibly soiled. 5. Interview on 9/24/26 at 9:54 a.m. with director of nursing (DON) B revealed he felt it was unacceptable for LPN Q to have missed the observed opportunities for hand hygiene. He expected the staff to use PPE that included a gown and gloves when caring for a resident with a catheter and on EBP, and to perform hand hygiene between tasks such as providing care and administering medication, and when entering and exiting a resident's room. 6. Review of the provider's March 2026 Transmission Based Precautions and Enhanced Barrier Precautions policy revealed that the staff were to use EBP and wear a gown and gloves when caring for residents with urinary catheters or feeding tubes. 7. Review of the provider's March 2026 Indwelling Urinary Catheter Use and Care policy revealed that the staff were to perform hand hygiene prior to putting on gloves, use gloves when caring for catheter sites, and perform hand hygiene after removing their gloves. 8. Review of the provider's March 2026 Hand Hygiene policy revealed that the staff were to perform hand hygiene with soap and water or with an alcohol based hand rub (hand sanitizer) immediately before touching a resident, before a clean procedure or handling an invasive medical device, after contact with a potential body fluid or contaminated surface, after touching a resident or the resident's immediate environment, and after removing their gloves.	F0880		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care.	F0552		11/08/2026

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F0552 SS = D	Continued from page 23 The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to protect the resident's rights to be informed of treatment by not ensuring that the staff educated the resident or the resident's representative of the risks versus benefits of medications or of alternative treatments to make an informed decision for consent to use psychotropic medications (drugs that affect brain activities associated with mental processes and behaviors) before they were administered to one of five sampled residents (59) who were reviewed for unnecessary medications. Findings include: 1. Review of resident 59's electronic medical record (EMR) revealed that he admitted to the facility on 6/2/26. His 6/2/26 Brief Interview for Mental Status (BIMS) assessment score was 2, which indicated his cognition was severely impaired. His diagnoses included Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions) and chronic depression (a mood disorder characterized by persistent feelings of sadness, worthlessness, and lack of interest in previously enjoyed activities). He had a 6/2/26 physician's order for quetiapine (an antipsychotic medication) 25 milligram (mg) tablet to be administered by mouth in the morning and one tablet before bedtime. He had a 6/2/26 physician's order for mirtazapine (an antidepressant medication)	F0552	**Corrective Action for Affected Resident** Resident #59's psychotropic medication record was reviewed and informed consent was obtained by RN Coordinator on 10/8/26. **Corrective Action for Affected Residents** 100% of residents receiving psychotropic medications will be reviewed to verify consent and informed decision-making documentation. Any deficiencies found during these reviews will be rectified promptly. These will be completed by October 30th, 2026. **Systemic Changes** The psychotropic medication policy was reviewed on 10/16/24 by the Administrator and Nurse Leadership team with no revisions recommended. The policy is a system standard policy that has been previously reviewed and approved by the Avera Health LTC Senior Services Division. Nursing staff will review resident's charts at their quarterly care plan meetings and verify documentation of consent and informed decision making is available for any psychotropic medications the resident is receiving. An IT ticket will be placed by October 23rd to request additional functionality in the EMR to allow nursing staff to quickly see if a resident has an order for a psychotropic medication and whether documentation of consent and informed-decision making exists. Staff will be educated at all-staff in-services related to the requirement for consent and informed decision-making prior to administering any psychotropic medications between 10/26/26 and 10/30/26 by the RN Supervisor, or designee. **Monitoring** The Director of Nursing, or designee, will audit 10 residents weekly for 8 weeks that have orders for psychotropic medications to verify documentation of consent and informed-decision making. The results of these audits will be reported to the facility QAPI team by the DON, or designee, for further direction.	11/08/2026

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F0552 SS = D	Continued from page 24 30 mg tablet to be administered by mouth at bedtime. There was no documentation in resident 59's EMR that indicated that resident 59's representative was notified and gave informed written consent for the use of the antipsychotic or the antidepressant medications, or that education regarding the risks versus benefits of the medications was provided, before those medications were administered to resident 59. 2. Interview and EMR review on 9/24/26 at 4:37 p.m. with registered nurse (RN) coordinator D revealed she was unable to find a consent for resident 59's psychotropic medications. The nursing staff would obtain a written consent from the resident or the resident representative, before a psychotropic medication was administered to the resident. Sometimes, she would obtain a verbal consent before a written consent was completed, so the medication could be started sooner. She would update the consent if there was an increase to a psychotropic medication but not for a decrease in the medication. 3. Interview on 9/24/26 at 4:40 p.m. with assistant director of nursing (ADON) C revealed she expected a resident who used a psychotropic medication to have the risks and benefits consent completed by the resident if able, or the resident's representative before the resident started the medication. 4. Interview and EMR review on 9/24/26 at 4:52 p.m. with director of nursing (DON) B revealed he checked resident 59's EMR and could not find a completed consent for the psychotropic medications. He expected the medications' risks and benefits to be reviewed with the resident or their representative, and the consent would be completed by the nurse, before the medication was administered to the residents. 5. Review of the provider's May 2026 Psychotropic Medications Use Long Term Care (LTC) Division policy revealed "Procedure: Prior to the administration of a psychotropic medication, the following includes a process for the interdisciplinary Team (IDT) and resident/resident representative to participate in the care process: A. The indication for any psychotropic medication will be thoroughly documented in the clinical record to include an appropriate supporting diagnosis and identification of behavioral symptom(s) being treated. The medical record must show documentation of adequate indication and diagnosed condition. I. Provide the resident/resident representative with information on the medication, indication, directions for use, dose,	F0552		11/08/2026

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F0552 SS = D	Continued from page 25 side effects, adverse consequences, risk/benefits of the medications, resident choice and goal of treatment. 1. Informed decision making with the resident and/or resident representative will be documented prior to initiation and before any dose increases."	F0552		
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 record review, interview, and policy review, the provider failed to ensure the residents' care plans (personalized plans that address a resident's care needs, goals, and interventions) were reviewed and revised to reflect the current care needs for one of one sample resident (31) with pain and Post-Traumatic Stress Disorder (PTSD) (a mental health condition that can occur after experiencing or witnessing a traumatic event, causing ongoing	F0657	**Corrective Action for Affected Residents** Resident #10's care plan will be updated to include hospice enrollment, goals, services, communication expectations, comfort-focused interventions, and coordination with hospice providers by 10/23/26. Resident #31's care plan will be updated to include PTSD, identified triggers, behavioral interventions, staff approaches, psychosocial supports, and individualized non-pharmacological pain interventions by 10/23/26. **Other Residents Potentially Affected** All residents who either receive hospice services, have behavioral health diagnoses, PTSD, recurring behavior documentation, or require individualized pain approaches will have their care plans reviewed by October 30th, 2026. Nursing staff will verify diagnoses, services, goals, and interventions are reflected in the care plan. **Systemic Changes** Facility process will be created to include updating or revising the care plan when a resident admits to hospice, has a significant behavior events, psychiatric diagnoses, significant psychosocial changes, and pain management changes by October 30th, 2026. A checklist will be created for RN Coordinators to use during quarterly reviews and significant changes to ensure appropriate care plan goals and interventions are in place. Education regarding person-centered care planning requirements, including specifically those on hospice, with behavioral health diagnoses, PTSD, or non-pharmacological pain management interventions during all staff inservices between 10/26/26 and 10/30/26 by the RN Supervisor, or designee. **Monitoring** Director of Nursing, or designee, will audit 10 care plans weekly for 8 weeks of residents that have hospice services, behavioral health diagnoses, pain management, or other significant psychosocial needs. Audits will verify that diagnoses, services, goals, and individualized interventions are present. The DON, or designee, wll report results o the facility QAPI committee and that group will guide further corrective actions.	11/08/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA PRINCE OF PEACE	**4513 SOUTH PRINCE OF PEACE PLACE , SIOUX FALLS, South Dakota, 57103**

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F0657 SS = D	Continued from page 26 intrusive memories, avoidance, negative mood changes, and heightened stress reactions), and one of one sample resident (10) who received hospice services. Findings include: 1. Review of resident 10's electronic medical record (EMR) revealed that he admitted to the facility on 3/3/26. His 9/22/26 Brief Interview for Mental Status (BIMS) assessment score was 12, which indicated that his cognition was moderately impaired. His diagnoses included hemiplegia (paralysis or severe weakness affecting one side of the body) and hemiparesis (partial weakness on one side of the body) following a cerebral infarction (an ischemic stroke caused by a blocked blood vessel in the brain) affecting his right side, unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities), depressive disorder, and dysphagia (difficulty swallowing). His 5/29/26 physician's order indicated that he admitted to hospice services. A 5/30/26 hospice care plan was completed by his hospice provider and outlined the care that hospice provided. His 9/24/26 care plan used in the facility did not indicate he received hospice services. 2. Interview and EMR review on 9/24/26 at 1:35 p.m. with licensed practical nurse (LPN) CC revealed that she could not find any indications that resident 10 was on hospice within his care plan. She expected to find that information in the care plan. 3. Interview and EMR review on 9/24/26 at 1:40 p.m. with registered nurse (RN) coordinator AA revealed that she could not find any indication that resident 10 was on hospice services in his care plan. She expected to find that information in the resident's care plan. 4. Interview on 9/24/26 at 1:52 p.m. with certified nursing assistant (CNA) EE revealed that she used the resident's care plans to know what care to provide to each resident. If the information she needed to care for the resident was not on the resident's care plan, she had to ask a nurse what care to provide. 5. Interview on 9/24/26 at 1:54 p.m. with RN supervisor GG revealed that she expected resident 10's hospice care plan information to be integrated into the facility's care plan. She was aware that he was on hospice and expected hospice provider and RN coordinator AA to input this into the care plan.	F0657		11/08/2026

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F0657 SS = D	Continued from page 27 RN coordinator AA was responsible for updating care plans within the transitional care unit. 6. Review of resident 31's EMR revealed he admitted to the facility on 7/14/25. His 9/14/26 BIMS assessment score was 15, which indicated his cognition was intact. His diagnoses were difficulty in walking, pain, and PTSD. His progress notes indicated that the nursing staff documented the resident using his personal cell phone to record live social media posts in his room that included slander and profanity related to staff members. These incidents led to internal security and law enforcement being called. His 5/30/26 care plan did not indicate a diagnosis of PTSD as a focus area or include interventions regarding resident 31's PTSD. His care plan indicated that the nursing staff was to administer pain medications as ordered and offer non-pharmacological pain management interventions. The care plan did not specify what non-pharmacological interventions the staff should provide for his pain. His 7/23/26 care plan did not include his behavioral information or any staff interventions regarding his behaviors related to name-calling, threatening behaviors, and social media live video usage while in his room. 7. Interview on 9/24/26 at 2:07 p.m. with RN coordinator AA indicated that she does not think the PTSD diagnosis, triggers, behaviors, or additional pain management interventions needed to be added to the resident's care plan because his pain was addressed by giving him the ordered pain medications as ordered by the physician. She said they addressed his behaviors when they happened and had security available if needed. 8. Interview on 9/24/26 at 2:08 p.m. with social services designee (SSD) BB revealed that she expected resident 31's PTSD diagnosis to be on his care plan with known triggers and interventions for the staff to help the resident manage his PTSD. 9. Interview on 9/24/26 at 2:37 p.m. with RN supervisor GG revealed that she expected resident 31's behaviors and PTSD to be in his EMR for the staff to be aware of. 10. Interview on 9/24/26 at 2:43 p.m. with CNA Z indicated that she used the resident's care plans to know how to take care of the residents and know what to watch for regarding their care and behaviors.	F0657		11/08/2026

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F0657 SS = D	Continued from page 28 11. Review of the provider's revised May 2026 Baseline/Comprehensive Care Plans LTC (long-term care) Division Policy revealed, "The interdisciplinary team will develop a baseline and comprehensive care plan for each resident, based on the admission assessments, assessment tools and the MDS [a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs] assessment to provide effective and person-centered care of the resident that meet[s] professional standards of quality care and to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being." 'Person-centered care' [means] to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives. Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the nursing home."	F0657		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).	F0732	**Corrective Action for Residents/Areas Affected** All long-term care areas/neighborhoods were assessed to determine the most prominent location to post the total number and actual hours worked and census by licensed and unlicensed nursing staff directly responsible for resident care per shift. **Identification of Other Residents/Areas at Risk** All long-term care areas/neighborhoods were assessed to determine the most prominent location to post the total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift. **Systemic Changes** The total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift will be posted in all long-term care neighborhoods at the beginning of each shift in a predetermined prominent area. All employees will be educated on the proper posting by the RN Supervior or designee the week of October 26th. **Monitoring** The Administrator or designee will monitor posting of the total number and actual hours worked by licensed and unlicensed nursing staff responsible for resident care per shift 2x per week for 12 weeks. The Administrator or designee will also check to ensure the correct census is recorded during this same audit. Results will be brought to the monthly QAPI meeting by the Administrator or designee for review and direction.	11/08/2026

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F0732 SS = C	Continued from page 29 (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the provider failed to ensure that the posted daily nurse staffing data included the current resident census and was in a location visible and accessible to all residents, staff, and visitors. Findings include: 1. Observation on 9/23/26 from 8:24 a.m. through 9:50 a.m. throughout the provider's Transitional Care Unit, Rehab, the first- and second-floor long-term resident care neighborhoods, and the provider's main entrance and common gathering areas revealed that the daily nurse staffing data could not be located. 2. Observation, interview, and review of the daily	F0732		11/08/2026

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F0732 SS = C	Continued from page 30 nurse staffing data on 9/24/26 at 2:51 p.m. with certified nursing assistant (CNA) G, CNA J, and licensed practical nurse (LPN) I in the Rehab resident care neighborhood revealed that they thought that the provider's daily nurse staffing data was posted in each distinct resident care neighborhood and included only the nurse staffing data for those staff members who worked in that specific resident care neighborhood. To know the provider's total daily nurse staffing data for the four resident care neighborhoods combined, they looked online in the provider's staffing schedule. The documentation LPN I provided, which she thought was the provider's 9/24/26 daily nurse staffing data for the Rehab resident care neighborhood, was posted on the cabinet above the counter in the nurses' station. LPN I was unsure whether she could share that information with residents or visitors because it included the names of the staff members who worked in the Rehab neighborhood that day. LPN I confirmed that the document that she provided did not include the total number and actual hours worked by registered nurses, licensed practical nurses, and certified nursing assistants per shift, or the facility's resident census. 3. Observation, interview, and review of the daily nurse staffing data on 9/24/26 at 2:51 p.m. with administrator A and registered nurse (RN) coordinator D in the first-floor long-term resident care neighborhood revealed that they thought that the provider's daily nurse staffing data was posted in each distinct resident care neighborhood and included only the nurse staffing data for those staff members who worked in that specific resident care neighborhood that day. The documentation RN coordinator D provided, which she thought was the provider's 9/24/26 daily nurse staffing data for the first-floor long-term resident care neighborhood, was posted on a clipboard that was turned upside down on a counter in the nurses' station. The data did not include the total number and actual hours worked by registered nurses, licensed practical nurses, and certified nursing assistants per shift, or the facility's resident census. 4. Observation, interview, and review of the daily nurse staffing data on 9/24/26 at 2:58 p.m. with administrator A in the second-floor long-term	F0732		11/08/2026

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F0732 SS = C	Continued from page 31 resident care neighborhood revealed that the documentation administrator A thought was the provider's daily nurse staffing data for the second-floor long-term resident care neighborhood was posted on a sheet of paper that was taped to the whiteboard on the cabinet above the counter in the nurses' station. The data did not include the total number and actual hours worked by registered nurses, licensed practical nurses, and certified nursing assistants per shift, or the facility's resident census. Administrator A felt that the information was readily available because the residents and visitors could ask any staff member for a copy. He thought the staffing hours could be added up easily to determine the total hours worked by each discipline per shift. 5. Interview on 9/24/26 at 3:29 p.m. with director of nursing (DON) B revealed that the scheduled night shift resource nurse posted the daily nurse staffing data in the Town Center activity room, which was located on the first floor outside of the Rehab resident care neighborhood and the first-floor long-term resident care neighborhood, each night. The daily nurse staffing data was not posted in each of the four resident care neighborhoods because he felt the Town Center activity room was accessible to all residents, staff, and visitors. He confirmed that residents who resided in the Transitional Care Unit resident care neighborhood, located across the campus from the Town Center activity room, would either have to cross the parking lot or travel through an assisted living and an independent living community to access the Town Center activity room, and that other residents lived on the second-floor long-term resident care neighborhood. He felt that staff members could assist residents to the Town Center activity room if they wanted that information. He expected CNA G, CNA J, LPN I, RN coordinator D, and administrator A to know that the daily nurse staffing data was posted in the Town Center activity room. He confirmed that the facility's long term care resident census on 9/22/26 was 137 residents and stated that there had been a couple of resident discharges and admissions since 9/22/26, but the census remained about the same. 6. Observation, interview, and review of the provider's daily nurse staffing data on 9/24/26 at 4:01 p.m. with LPN I in the Town Center activity	F0732		11/08/2026

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F0732 SS = C	Continued from page 32 room revealed that she was told by RN coordinator FF a few minutes earlier that the daily nurse staffing data sheet was located in the Town Center activity room and was asked to show it to the surveyor. The daily nurse staffing data sheet was posted inside the Town Center activity room. The Town Center activity room had retractable doors that were open during resident activities. Those doors were closed. One entrance opened to the main corridor that lead to the provider's main lobby, and a second entrance opened near the elevator outside of the Rehab resident care neighborhood and the first-floor long-term resident care neighborhood. The daily nurse staffing data sheet was posted on the wall adjacent to the door frame between the door that exited to the main corridor and the upper cabinets above the counter. LPN I confirmed the posting was about five feet from the floor and may not be visible to a resident in a wheelchair. She acknowledged that residents' family members and visitors did not pass through the Town Center activity room to access any of the resident care neighborhoods. The daily nurse staffing data sheet indicated a resident census of 183. LPN I stated that the resident census number did not seem correct because it indicated more residents than she thought were in the long-term care facility, and wondered if that census included residents who resided in the provider's assisted living facilities. 7. Review of the provider's current South Dakota Department of Health Nursing Facility Long Term Care License effective 7/1/26 revealed that the provider was licensed for 142 resident beds. 8. On 9/24/26 at 4:36 p.m., a copy of the provider's policy regarding the posted nurse staffing data was requested from administrator A and was not received by 12:00 p.m. on 9/25/26 as requested.	F0732		11/08/2026