

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026
NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST , WINNER, South Dakota, 57580	
(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 An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/26/26 through 5/28/26 and 6/1/26 through 6/2/26. Winner Regional Healthcare Center was found not in compliance with the following requirements: F552, F585, F600, F605, F609, F655, F657, F700, F712, F755, F756, F761, F835, F865, F944, and F947, with an Immediate Jeopardy violation at F689. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/26/26 through 5/28/26 and 6/1/26 through 6/2/26. Areas surveyed included potential staff-to-resident abuse, and accident hazards related to a hot liquid spill which resulted in a resident being burned. Winner Regional Healthcare Center was found not in compliance with the following requirements: F585, F600, F609, and F689.	F0000		
F0689 SS = SQC-K	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: A. Based on observation, interview, record review, and policy review, the provider failed to ensure resident safety by not assessing the side rails/grab bars and mattresses on the resident's beds for entrapment (trapped between the rail, mattress, or bedframe spaces) for four of six sampled residents	F0689		

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 7.16.26
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F0689 SS = SQC-K	Continued from page 1 (17, 21, 25, and 26) with loose side rails/grab bars on their beds, five of six sampled residents (6, 14, 17, 21, and 25) with an unsecured mattress on their bed, and one of six sampled residents (17) with a side rail/grab bar that was not indicated for use on the bed. Those failures put those residents at risk for entrapment, injury, or harm. Immediate Jeopardy (IJ) at F689, with a scope and severity of "K," began on 5/28/26 at 10:05 a.m. upon observation of resident 14's bed. The bed was unlocked and moved away from the wall; the mattress slid away from the side rail/grab bar with minimal effort, creating a gap of more than five inches. The bed frame did not have mattress guards, which held the mattress in place, preventing the mattress from sliding when a side rail/grab bar was on the bed, putting the resident at risk for entrapment, injury, or harm. Chief executive officer A and director of nursing (DON) B were notified of the IJ on 5/28/26 at 12:45 p.m., and a removal plan was requested. The edited removal plan was received on 5/28/26 at 3:03 p.m. and was accepted on 5/28/26 at 5:10 p.m. The IJ was removed on 5/28/26 at 5:25 p.m. as confirmed by onsite verification by the survey team. After the IJ removal, the severity of non-compliance remained at a "G." Current census was: 27 Findings include: 1. Observation on 5/27/26 at 9:52 a.m., with resident 6 and resident 14 in their shared room, revealed that a right-side rail/grab bar was attached to each bed. Their mattresses were not securely attached to the beds and created a gap between the side rails/grab bars and the mattresses when the mattresses moved. The gap between resident 14's bed and the side rail/grab bar measured four and a half inches when the mattress slid to the wall when touched. 2. Observation on 5/27/26 at 9:53 a.m. with resident 17 in her room revealed that she had a side rail on the left side of her bed, which was up against a wall in her room. The side rail was loose and could be pulled away from the bed. It was not properly attached to the bed and was held in place with a zip tie. The side rail's bar was not attached to the frame of the bed, was unsecured under the mattress, and could move around.	F0689	- Resident #17: Bed was immediately removed and replaced with a bed equipped with appropriate, secure bedrails. - Resident #21: Bedrails were removed as they were not clinically indicated. - Residents #25 & #26: Bedrails were immediately tightened and secured to eliminate instability. - Resident #25: A 5-inch gap between mattress and headboard was immediately corrected by placing a tightly rolled comforter/bolster (this is temporary) to eliminate the entrapment zone. Residents #6 & #14: Mattresses were secured using manufacturer-approved metal corner brackets on all four corners, eliminating gaps between mattress and rails. - Bedrails were removed in four resident rooms where they were not needed for mobility or positioning. - The Administrator, Director of Nursing (DON), and Maintenance conducted immediate room-to-room audits of all beds. - All entrapment zones were assessed and measured, ensuring compliance with less than a 4.75 inches in total. - Immediate corrective actions included: - o Installation of manufacturer-approved brackets - o Temporary gap reduction (rolled comforters/bolsters) until permanent fixes completed - o Ordering manufacture approved corner brackets - o Brackets will be installed as soon as they arrive to the facility by maintenance.	

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F0689 SS = SQC-K	Continued from page 2 3. Observation on 5/27/26 at 9:54 a.m., with resident 26 in his room, revealed he had side rails/grab bars on both sides of his bed. The rail/grab bar on the right-handed side of the bed was loose and moved approximately four inches away from the mattress when touched. 4. Observation on 5/27/26 at 10:06 am, with resident 21 in his bed, revealed that he had a rail on the right side of his bed, which was loose, with a four-inch gap between the loose rail and his mattress. The left side of his bed was up against the wall. 5. Observation and interview on 5/27/26 at 9:58 a.m. with resident 25 in his room revealed that he had side rails on both sides of his bed. The right-side rail was loose and could be pulled away from the bed. The left side of the bed was positioned against the wall. Resident 25 was lying in bed with his head resting against the left side rail. He did not use the side rails for transferring in or out of bed or repositioning while he was in bed. There was a gap between the headboard and the head of the mattress that was unable to be measured at that time with resident 25 lying in the bed. 6. Observation on 5/27/26 at 12:04 p.m. of resident 25's bed revealed there was a five-inch gap between the top of the mattress and the headboard. The loose rail on the right side moved four inches away from the mattress when pulled on. The left side rail was securely attached to the bed. 7. Review of resident 25's electronic medical record (EMR) revealed he admitted to the facility on 1/9/24. He had a Brief Interview of Mental Status (BIMS) assessment score of 15, which indicated his cognition was intact. His diagnoses included alcohol induced dementia (a group of symptoms affecting memory, thinking, and social abilities caused by excessive prolonged use of alcohol), and an eye movement disorder. His 5/28/26 care plan indicated that resident 25 was unable to see out of his left eye. Resident 25's 1/9/24 side rail and safety screen indicated bilateral side rails were recommended to be installed by occupational therapy due to "[Resident 25] was using bed rails in [the] hospital. Without them he requires increased assistance. Recommending Bilateral [bed] rails." There was no documentation that indicated when resident 25's side rails were installed. A 10/8/25 progress note indicated resident 25 "fell on his face over his bed hitting the headboard and	F0689	· A audit of all beds and mattresses in the facility was completed by: - o Administrator - o Director of Nursing - o Maintenance staff · All residents with: - o Bedrails - o Assistive devices - o Specialty mattresses were evaluated for safety - o Entrapment zones (Zones 1–7 where applicable) - o Mattress fit and stability - o Rail security The facility implemented the following systemic changes: Equipment & Environment · Only manufacturer-approved bedrail and mattress systems will be used. · All beds must have: - o Securely attached rails (if used) - o Properly fitted mattresses - o No gaps exceeding allowable limits · Metal corner brackets required for mattress stabilization where applicable. 4. MONITORING SYSTEM The facility will implement the following monitoring: · Weekly audits until brackets arrive · Monthly audits · This will continue monthly with no stop date Audit includes: · Bedrail stability · Mattress fit and securement · Entrapment zone measurements	

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F0689 SS = SQC-K	Continued from page 3 lacerating [cutting] his nose on the right side." He was sent to the emergency room for further assessment. 8. Observation on 5/27/26 at 12:05 p.m. of the bed in resident 21's room revealed the gap between the loose rail on the right side of the bed and his mattress measured five inches when the mattress slid to the wall and the loose rail was pulled out from the bed. The gap measured four and a half inches between his headboard and the head of the mattress. 9. Interview and observation on 5/28/26 at 10:05 a.m., with DON B in resident 14 and 6's shared room revealed she was unaware that the side rails/grab bars and mattresses needed to be assessed for entrapment risks. She was unsure if maintenance assessed the side rails or mattresses for entrapment risk in any "zones [specific areas around a hospital bed where a resident's head, neck, or chest can get wedged]." When a resident or their representative requested a side rail/grab bar, the therapy department would assess the resident using a checklist. The checklist did not contain resident risk for entrapment, any interventions tried before the use of the side rail/grab bar, or indicate that the resident's consent for the use of the side rail/grab bar was needed. She thought that if a resident wanted a side rail/grab bar, they could request one, and one would be provided. Resident 14's bed was not locked, the bed was moved away from the wall, and the mattress slid away from the bed rail with minimal effort when pushed, which created a large gap of more than five inches. She confirmed that the bed did not have the mattress guards to hold the mattress in place and prevent the mattress from sliding when a side rail/grab bar was attached to the bed frame. Resident 6's bed did not have the mattress guard. She confirmed that resident 14 and resident 6's beds had potential risks for entrapment between the side rail/grab bar and the mattresses. 10. Review of the maintenance clipboard in the charting conference room revealed there were no resident beds or side rail repair requisitions from 3/18/26 through 5/28/26. 11. Interview on 6/1/26 at 11:56 a.m. with DON B revealed there was no documentation available related to when the side rails were installed on the residents' beds.	F0689	Audit completed by maintenance/DON was taken to LTC QAPI on 6/23/26 with 100% compliance for the week of 6/4/26, 6/8/26, 6/15/26 and 6/22/26. Additionally, to the audit a spot for is the resident at risk for entrapment was added on 6/25/26 audit with this information will begin week of 6/29/26. Audits will continue to be completed by DON/Maintenance or designee. Presented to QAPI by DON or designee. This will be done on all beds until bed brackets arrive, weekly, then go to monthly on all beds, and ongoing monthly with no stop date.	7/9/2026

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F0689 SS = SQC-K	Continued from page 4 12. Interview and review of the maintenance "Inspection of Bed Frame w[with]/Mattress and Side Rail Audit" on 5/28/26 at 12:04 p.m., with CEO A revealed that the audit was dated "12/06" through "1/13." There was no documentation to identify the year the audit was completed. CEO A thought that maintenance supervisor GG was responsible for assessing the side rails/grab bars, beds, and mattresses for entrapment risk. CEO A stated that maintenance supervisor GG ended his employment on 5/27/26, and CEO A was unable to access information about the installation or inspection of the side rails/grab bars, beds, or mattresses on maintenance supervisor GG's computer. CEO A was unsure if maintenance supervisor GG had inspected the side rails/grab bars, beds, or mattresses, and stated that maintenance supervisor GG was unavailable for an interview. CEO A thought that former maintenance supervisor I completed the bed inspections. There was no maintenance staff member available to interview related to the installation or inspection of side rails/grab bars, beds, or mattresses. 13. Notice of immediate jeopardy (IJ) of F689 was given verbally and in writing on 5/28/26 at 12:45 p.m., to CEO A and DOB B regarding the resident's side rails not being securely attached and the mattresses on residents' beds not being assessed for entrapment risks. Observations made throughout the survey and throughout the long-term care facility from 5/27/26 through 5/28/26 revealed there were several safety concerns related to bedrail installation, maintenance, and bed zone assessments. Residents 17, 21, 25, and 26 had side rail(s)/grab bar(s) that were not securely attached, which created entrapment risks and risk for injury. Resident 25 had a five-inch gap between the top of his mattress and his headboard, which created entrapment risk and risk for injury. Residents 6 and 14 had mattresses that were not securely attached to the bed and created a gap between the side rail/grab bar and the mattress, which created entrapment risks and risk for injury. Resident 17 had a side rail/grab bar that was not indicated for use on that bed, and the side rail/ grab bar was loosely secured to the bed frame with a	F0689		

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F0689 SS = SQC-K	Continued from page 6 2. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS AT RISK: A[n] audit of all beds and mattresses in the facility was completed by: Administrator, Director of Nursing, Maintenance staff. All residents with: Bedrails, Assistive devices, Specialty mattresses were evaluated for: Entrapment zones (Zones 1–7 where applicable), Mattress fit and stability, Rail security. 3. MEASURES PUT IN PLACE / SYSTEMIC CHANGES: The facility implemented the following systemic changes. Equipment & Environment: Only manufacturer-approved bedrail and mattress systems will be used. All beds must have: Securely attached rails (if used), Properly fitted mattresses, No gaps exceeding allowable limits, Metal corner brackets required for mattress stabilization where applicable. 4. MONITORING SYSTEM: The facility will implement the following monitoring: Weekly audits x [for] 4 weeks, then; Monthly audits x 3 months, then; Quarterly thereafter. Audit includes: Bedrail stability, Mattress fit and securement, Entrapment zone measurements. Audits will be completed by: Maintenance or designee. Results will be reviewed through: QAPI [quality assurance and performance improvement] Committee. 5. STAFF EDUCATION: All staff (nursing, maintenance, and leadership) will be educated on: Bed safety and entrapment policy will be review [reviewed] with immediate staff by DON/Administrator. All staff will be educated prior to start of next shift. Weekend staff will be educated by Administrator or DON. Proper installation of bedrails and mattress systems, Side rail policy reviewed, Identification of entrapment zones, Immediate reporting and correction process. Education will be completed: Immediately upon IJ identification, During annual competency validation, For all new hires." 15. The immediacy was removed on 5/28/26 at 5:25 p.m. after the survey team verified on-site that the provider had implemented their removal plan through observation, document review, and staff interviews. After the removal of the IJ, the scope and severity of the noncompliance remained at an E. Current census was 27 residents. 16. Review of the provider's revised 1/6/25 Side	F0689			

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F0689 SS = SQC-K	Continued from page 7 Rail policy revealed "Quarter rails and bed canes [grab bars] that are approved for the beds can be used that are affixed to the bed and evaluated for safety and functioning by maintenance...Maintenance will be notified with side rail evaluations and prn [as needed] for an inspection of the side rail, how it fits the bed, tightness, and to evaluate the mattress for wear and distance from the rail." 17. Review of the provider's undated Bed Safety and Entrapment Prevention Policy revealed that the purpose was "To ensure a safe sleeping environment by preventing bed-related accidents, including entrapment, falls, and injury related to bedrails, mattresses, and bed systems." "The facility is committed to maintaining all beds, mattresses, and assistive devices in a safe condition. Bed systems will be assessed, maintained, and used in a manner that minimizes the risk of entrapment and injury, in accordance with CMS [Centers for Medicare and Medicaid Services] F689 requirements and FDA [Food and Drug Administration] bed safety guidance. Bedrails will not be used as restraints and will only be utilized when clinically indicated and safe." "All beds must: Be in good working condition, Have securely attached side rails or assistive devices (if used), Have a properly fitted mattress, Be compatible with all components (no mixing of incompatible parts), Be free of excessive gaps." "All gaps must measure $\leq$ [less than or equal to] 4.75 inches where applicable." "Special attention is given to: Space between mattress and rail, Mattress and headboard/footboard, Split rails and joints." "Bedrails will: Only be used when clinically necessary. Require: Assessment prior to use, Care plan documentation, Be removed when: Not used for mobility or positioning, Risk outweighs benefit." "Mattresses must: Fit securely within the bed frame, Not slide, shift, or leave gaps, Be secured using: Manufacturer-approved systems (e.g., corner brackets or stops), Be replaced if worn or incompatible." "Initial and Routine Assessments The following will be completed: On admission, With change in condition, Quarterly and annually, After any bed or mattress change. Assessment includes: Bedrail necessity, Mattress fit and stability, Entrapment zone measurement."	F0689		

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F0689 SS = SQC-K	Continued from page 8 "Staff Responsibilities: All Staff: Assess need for bedrails, Monitor for signs of entrapment risk, Report hazards immediately. Maintenance: Ensure all beds are properly assembled, Perform repairs and installations, Maintain approved equipment only, Monthly audits on all beds. Administration: Ensure policy compliance, Monitor through [the] QAPI process." B. Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and observation, the provider failed to ensure the safety of one of one sampled resident (5) who was not assessed for her ability to safely drink hot liquids and spilled hot tea on her lap and sustained a hot liquid burn injury, and one of one sampled resident (10) who was not assessed for her ability to safely use her personal coffee maker in her room. Findings include: 1. Review of the provider's 12/23/25 SD DOH FRI report revealed that on 11/19/25, it was reported that resident 5 spilled her hot tea in the dining room, which resulted in a 0.25 centimeter (cm) blister on her right inner thigh, and both inner thighs were red. Bacitracin (an antibiotic ointment) was applied to the blister, and it was covered with a bandage. Resident 5 told a family member that a staff member spilled the hot tea on her. On 12/22/25, resident 5's family member told registered dietitian (RD) H that she thought that a staff member spilled the hot tea on resident 5. On 12/22/25, CEO A and DON B interviewed resident 5, and resident 5 provided inconsistent information about who spilled the hot tea. An unidentified certified nursing assistant (CNA) was interviewed and stated that resident 5 was holding her teacup while the CNA added honey to the hot tea, and "then the resident [5] tipped over the cup, into her lap." The unidentified CNA stated she immediately used cloth clothing protectors to absorb the hot tea, took resident 5 to her room, assisted an unidentified nurse to remove resident 5's pants, and cool packs were applied. An unidentified nurse, who the report identified as no longer working at the facility, was interviewed, and there was "no change in the above" information provided by the unidentified CNA. Dietary manager (DM) G interviewed an unidentified dietary aide who worked on 11/19/25, and the	F0689		

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F0689 SS = SQC-K	Continued from page 9 unidentified dietary aide recalled hearing resident 5 "cry out," and did not see how the spill occurred. The provider determined that resident 5 spilled her hot tea on her leg. DM G implemented a "lid" policy, and resident 5 was to have "a little water or ice added" to her hot beverages, and a lid was to be on the cup when the cup of hot tea was served to resident 5. All hot drinks were to be served with a lid to all residents. The resident or a CNA, upon request by the resident, was the "only one that can remove the lid." The lids were not allowed to be removed by the dietary staff members. The temperature on the hot water/coffee machine was not monitored on 11/19/25. The staff were to be trained by 1/5/26 to monitor the temperature of the hot water/coffee machine daily. The temperature of the hot water/coffee machine was monitored after the incident on 11/19/25, and that temperature was in the range of 125-140 degrees Fahrenheit (F). The hot water/coffee machine was inspected and serviced by the coffee company's representative/technician. The provider contacted an unidentified person at the Department of Health and was told that a maximum temperature for hot drinks was "not determined by any regulation." Resident 5's blister healed with "no residual effect or infection," and her care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was updated to reflect the need for a lid to be used on her hot beverages, and ice was to be added to her tea. The provider determined the incident was not the result of abuse or neglect. The report indicated that the "provider, family, and DON" were notified of the incident. 2. Review of resident 5's EMR revealed she admitted to the facility on 3/11/25. Her 5/19/26 Brief Interview of Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact. She had a diagnosis of Alzheimer's Disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions). An 11/19/25 nursing progress note revealed "Staff reported that resident [5] was in the dining room when she spilled hot tea in her lap. Resident [5] was taken to her room and [her] pants [were] removed immediately. Cool packs [were] applied. Resident [5]	F0689		

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F0689 SS = SQC-K	Continued from page 10 has a 0.25 cm blister on [her] right inner thigh. Both inner thighs are red. Bacitracin applied to [the] blister covered with Telfa [a bandage]. [The] provider and family and DON [were] notified." There was an 11/19/25 physician's order for cool packs, Bacitracin, and a bandage to be applied to resident 5's right inner thigh. Resident 5's Skin Observations revealed that on 11/24/25, she had a blister on her right inner thigh that measured 1.5 cm by 0.75 cm, and the leg was tender to touch. On 12/1/25, the "Burns spots on [her] inner thighs are peeling. Wound bed [was] pink, no drainage [was] noted. Areas [were] left open to air." On 12/8/25, there were "no new skin issues noted...normal skin color, warm to touch." No documentation indicated when the hot liquid burn injury healed. A 12/23/25 progress note written by RD H revealed that she was at the facility on 12/22/25, and resident 5's family member came to her office "for follow up regarding the hot liquids in the dining room as discussed during her [resident 5's] care conference on 12/9/25." RD H informed resident 5's family member that DM G adjusted and was monitoring the temperature of the hot water/coffee machine, that the staff members were instructed to add ice to resident 5's hot liquids to cool them, and resident 5 was to have a lid for her hot liquids to reduce the risk of burning herself. RD H reported the conversation to assistant DON C, licensed social worker (LSW) E, and social services designee (SSD) F on 12/22/25 and to DON B and the interdisciplinary team (ADT) at the IDT meeting that morning on 12/23/25. Resident 5's updated 3/10/26 care plan had a focus area that indicated on 11/19/25, resident 5 spilled hot tea on herself, and had a 0.25 cm blister on her right inner thigh. Interventions included that she was able to feed herself after set-up assistance was provided, she had a "burn issue with hot tea in the dining room in November 2025," and that she was to have ice added to her hot liquids and a white lid on her cup to decrease the risk of burning herself by hot liquids. There was no documentation that a hot liquid assessment was completed. 3. Observation and interview on 5/27/26 at 8:13 a.m. with resident 5 revealed she had her breakfast of bacon, eggs, toast, and a bowl of oatmeal in front of her. Her hot tea did not have a lid. She answered questions with, "yes" or "no" and indicated that she did not have ice in her tea and did not like a lid on	F0689			

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F0689 SS = SQC-K	Continued from page 11 her tea. 4. Observation and interview on 5/27/26 at 10:52 a.m. with DM G revealed the water in the hot water/coffee machine was 164 degrees F. She was unsure what the temperatures of the hot water/coffee would have been in November 2025 because they did not monitor the temperatures until 12/24/25, after resident 5 sustained a hot liquid burn injury from her hot tea. She expected the temperature of the hot water/coffee to be under 180 degrees F for it to be safe to serve to residents. There was no hot beverage policy until December 2025. All residents were served their hot beverages in an open hot beverage cup until the hot beverage policy was implemented. All of the residents who were served a hot beverage by a dietary staff person must have a lid on that hot beverage. The lids were used to prevent a hot liquid burn injury, not to keep the beverage hot. The CNAs were not required to serve all residents their hot beverages with a lid because the CNAs knew which residents needed a lid and which residents did not need a lid. The residents could remove the lid once the hot beverage was served by a dietary staff member, or a CNA could remove the lid if the resident asked that the lid be removed. Some residents did not need the lids, but she did not know who they were. She educated the dietary staff about the use of the lids on the hot beverage cups and the new policy, but did not keep documentation of when that education was provided or who she educated. She did not work on 11/19/25 when resident 5 spilled her tea and was burned. She was not notified that resident 5 received a hot liquid burn injury until "a few weeks" after it occurred. 5. Phone interview on 5/27/26 at 4:34 p.m. with resident 5's family member regarding resident 5's 11/19/25 hot liquid burn injury revealed she visited resident 5 on 11/24/25 and was told by resident 5, "they burned me," and resident 5 showed her the inner thigh area. She was resident 5's emergency contact, and no notification was provided to her or the other listed emergency contact. While at the facility on 11/24/25, she spoke with a nurse (she was unable to recall who) about the incident and was told that the documentation in resident 5's EMR said that resident 5 spilled her own "coffee" in her lap and that the resident's emergency contact was notified.	F0689		

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F0689 SS = SQC-K	Continued from page 12 She stated that resident 5 was "coherent," and repeated several times, "they burned me," and that she believed resident 5. She told the nurse that she thought a staff member caused resident 5's burn injury and that she was upset that she and the resident's other emergency contact person were not notified. Resident 5's family member attended resident 5's 12/9/25 care conference meeting and told the staff that she was concerned that a staff member caused resident 5's burn injury, and that she and the resident's other emergency contact person were not notified. She recalled that RD H was present at that care conference and said she would "check into it." On 11/23/25, she "stopped to visit" with RD H because she was not provided any additional information about what happened when resident 5 was burned or what the facility was doing about it. She was told the hot water machine was "over-temperature," the staff members were to put ice in resident 5's hot tea, and resident 5 was to drink her tea out of a cup with a lid. Resident 5's family member was upset because resident 5 did not like the lid on her cup, and she felt that resident 5 was safe to drink hot liquid out of a cup without a lid. She felt resident 5 did not spill her hot tea on herself and should be allowed to drink her tea without ice or a lid. She was not aware if or when the hot liquid burn injury healed. She stated that she hoped that an incident like this would not happen again or happen to anyone else. 6. Review of resident 5's 12/9/25 Care Conference Assessment revealed that resident 5, her family member, RD H, assistant DON C, and social services designee (SSD) F attended that care conference. Resident 5's family member discussed her concerns about resident 5's burn injury from her hot tea. 7. Observation and interview on 5/27/26 at 5:11 p.m. in the dining room with resident 5 and contracted travel CNA S revealed resident 5 had a plastic cover on her hot tea. Contracted travel CNA S stated that no residents received ice in their hot beverages, but she would put ice in their hot beverages to cool them, if they asked. All residents were served their hot beverages in a cup with a lid, and the resident or the staff could remove the lid for the resident after it was served. 8. Interview on 6/1/26 at 12:17 p.m. with DON B regarding resident 5's 11/19/25 hot liquid burn injury revealed that she was notified on 12/22/25	F0689		

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F0689 SS = SQC-K	Continued from page 13 that resident 5's family member was stating that resident 5 was burned by a hot liquid and that she thought that a staff member caused the burn injury. DON B was not notified on 11/19/25 that resident 5 received a hot liquid burn injury, and did not expect to be notified because the hot liquid burn injury was not serious enough to require a visit to the emergency room, and the staff thought that resident 5 had spilled her hot tea on herself. CEO A and DON B began their investigation into resident 5's 11/19/25 hot liquid burn injury on 12/23/25. The results of their investigation were entered into the SD DOH reporting system, and then the information was shredded. The provider determined that resident 5 spilled her hot tea on her lap, causing the hot liquid burn injury. Hot liquid safety assessments were not completed on any residents. DM G initiated a policy that all residents were to have lids on their hot tea or coffee, and resident 5 was to have ice added to her hot beverages. Those interventions were added to resident 5's care plan. She was unaware that resident 5 was not provided ice in her hot tea, but resident 5 was allowed to remove the lid from her hot tea. 9. Phone interview on 6/1/26 at 3:53 p.m. with contracted travel CNA U regarding resident 5's 11/19/25 hot liquid burn injury revealed she worked during the evening meal that day. Resident 5 held her teacup up in the air, indicating that she wanted more hot tea and honey. Contracted travel CNA U refilled resident 5's cup and then set it on the table. After she walked away, she heard resident 5 scream that she spilled her hot tea in her lap. She felt that it was a few seconds after she walked away that resident 5 spilled the hot tea. Contracted travel CNA U stated the hot tea pooled in resident 5's lap, she used cloth clothing protectors to soak up the hot liquid, and pushed resident 5 quickly out of the dining room and back to her room to change her pants. She did not think that anyone was near resident 5 when her hot tea spilled. The facility implemented a new policy that all residents were to be served their hot beverages in cups with a plastic lid. They did not use the hot beverage cup lids before the 11/19/25 incident with resident 5. All residents were allowed to have hot beverages, and all residents were required to use the plastic lids. There was no list of residents who were allowed to have the covers removed, but she knew that some residents could remove the lids themselves or ask the nursing staff members to	F0689	Resident 5 A Hot Liquid Risk Assessment will be completed by 7/1/2026. The Director of Nursing (DON) met with Resident #5 on 6/8/2026 to review concerns related to hot liquid safety following the identified burn. The DON discussed the recommendation to utilize a lidded cup to reduce the risk of further injury. Resident #5 adamantly refused the use of a lid, stating, "I will not drink with a white lid." The DON provided education regarding the risks and benefits of hot liquid safety interventions, including the potential for burns and injury. After discussion, Resident #5 agreed to an alternative intervention of adding ice to hot beverages to reduce temperature, although she stated she would only allow it to cool "a bit." A risk/benefit agreement was completed and signed by Resident #5 on this date. The resident's family member was notified, and the attending physician was informed and signed the agreement. The DON also signed the agreement. The resident's care plan will be updated to reflect: - Resident preference to refuse lid use - agreed-upon intervention of adding ice to beverages - Ongoing education and monitoring for safety Staff will provide increased observation during hot liquid consumption and continue to offer safer alternatives while respecting resident rights.	7/9/2026

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

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F0689 SS = SQC-K	Continued from page 14 remove the lid for them. 10. Interview on 6/2/26 at 8:25 a.m. with RD H regarding resident 5's 11/19/25 hot liquid burn injury revealed she learned of the injury during resident 5's 12/9/25 care conference. The hot water/coffee machine was serviced by the distributor to ensure the temperature was safe. A hot beverage assessment was considered for resident 5, but the provider's current EMR system did not have one, so that assessment was not completed. Resident 5 was to have ice added to all of her hot beverages, and the use of plastic lids on all hot beverages was implemented. CNAs were allowed to remove the lids for residents who requested them removed. There were no residents who were not served hot beverages due to the risk of hot liquid burn injuries. The need for ice to be added to resident 5's tea was not on resident 5's meal ticket, but she thought that the staff knew that she needed it. RD H was unaware that ice was not being provided in resident 5's hot beverage, but resident 5 could have the hot beverage cup lid removed from her cup by a nursing staff member when she requested it removed. The temperature of the hot water/coffee machine was not monitored until 12/24/25. She thought that it was determined that resident 5 spilled her own hot tea. 11. Multiple attempts were made throughout the survey to interview resident 5. She answered simple yes-or-no questions, but when asked for details, she looked away and did not provide any further information. 12. Observation on 5/26/26 at 3:42 p.m. of resident 10's room revealed she had a personal coffee maker in her room. There were four ceramic coffee mugs beside the coffee maker, and two of those mugs had a blue colored liquid in them. 13. Review of resident 10's EMR revealed she admitted to the facility on 1/7/25. Her 3/12/26 BIMS assessment score was 14, which indicated her cognition was intact. There were no hot liquid safety assessments in her EMR. Her 5/27/26 care plan did not indicate she had a personal coffee maker in her room or that was assessed to be able to safely use it. 14. Interview on 5/27/26 at 2:45 p.m. with DON B revealed she was aware resident 10 had a personal	F0689		

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F0689 SS = SQC-K	Continued from page 15 coffee maker in her room. Her family had brought it in for her. It was left in the room because it was resident 10's right to have the coffee maker in her room. There were no hot liquid safety assessments completed on any of the residents within the facility. DON B was asked if there was any documentation related to resident 10 and her family being educated on the risks of the coffee maker in her room, or an assessment that resident 10 was safe to use the coffee maker. DON B stated she did not think there was any documentation to support that risks were reviewed, or that a safety assessment had been completed. DON B was asked to provide any documentation she was able to find, and no documentation of a safety assessment or that resident 10 and her family were educated on the risks of the coffee maker was provided by the end of the survey. 15. Interview on 5/28/26 at 8:58 a.m. with resident 10 revealed she used her personal coffee maker every day since she was admitted to the facility on 1/7/25. When she was admitted, a staff member watched her make a cup of coffee using that machine, but no one had observed her making coffee since her admission. The staff did not review the risks of her using the coffee maker in her room. She denied having burned herself with coffee or hot water from the coffee maker. The cups with the blue liquid were dirty cups that she put dish soap and water in. Her family would take the dirty coffee cups home and wash them, or she could send them to the kitchen to be washed in the dishwasher. 16. Review of the provider's Hot Liquid Temperature monitoring logs revealed that the monitoring of the provider's coffee/hot water machine located in the Long Term Care Dining Room began on 12/24/25. The temperature log was completed daily after that, and the documented temperatures ranged from 132 to 169 degrees F. 17. Review of the provider's 12/23/25 Food and Nutrition Service Hot Liquid Policy revealed that it was developed by the director of food and nutrition services, but was not reviewed or approved. The purpose was "To implement appropriate precautions that maximize choice of hot liquids to residents and patients, while minimizing risk of injury through comprehensive assessment in tailored interventions." "Risk Identification: Hot liquids pose a burn risk,	F0689	Resident #10 A Hot Liquid Risk Assessment will be completed by 7/1/2026. On 6/8/2026, the Director of Nursing (DON) met with Resident #10 regarding the use of a personal Keurig coffee maker in her room. Resident #10 stated that she has never experienced injury to herself or others related to its use. The DON provided education on the risks and benefits associated with hot liquid use, including the potential for burns and injury. Following this discussion, a new risk/benefit agreement was completed and signed by Resident #10 on 6/8/2026. The DON also discussed this with Resident #10's son, who verbalized agreement that the resident is safe to continue use of the Keurig. He declined removal of the Keurig from the resident's room and signed the risk agreement acknowledging understanding of the associated risks. The attending physician was notified. The resident's care plan will be updated to reflect: - Continued use of personal Keurig - Education provided regarding risks - Signed risk/benefit agreement - Ongoing monitoring for safe use	

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F0689 SS = SQC-K	Continued from page 16 particularly for residents/patients with weakened motor skills, balance issues, cognitive impairments, or musculoskeletal/neurological conditions. These conditions increase vulnerability to burns and complications as fragile skin takes longer to heal." "Resident Choice-Resident/patients who express a preference for hot liquids (e.g. coffee, tea, cocoas, or soup) will not be restricted from enjoying these options." "Assessment Process: A hot liquid assessment will be conducted for each resident: Upon Admission, Annually, Following any significant change in health or functional status, or when a safety concern is identified." "Risk Mitigation Interventions: To minimize burn risks...with additional measures that MAY be taken based on individual assessments: Hot liquids temperatures will not exceed 180 degrees fahrenheit [Fahrenheit], Hot liquids such as coffee, tea, or cocoa will be served in a cup with a sippy or sip-n-lock lid..." "Dietary Employees will not be permitted to remove the lid for the resident/patient. The patient can choose to remove the lid or can ask Nursing staff to assist with removing the lid. (Dietary employees do not have access to Hot Liquid Assessments and therefore should not make decisions regarding the resident or the patient's ability to avoid a burn if the lid is removed from the cup/glass/mug." "Temperature of hot liquid source... will be temperature checked and logged each morning..." "ALL BURNS MUST BE REPORTED TO DIRECTOR OF NURSING/CHARGE NURSE AND DIETARY DIRECTOR"	F0689	All residents will have a Hot Liquid Risk Assessment completed by 7/1/2026. The facility developed and implemented a Hot Liquid Safety Policy & Procedure on 6/25/2026. Staff education on this policy will be completed by 7/9/2026. Moving forward: · All new admissions/readmissions will have a Hot Liquid Risk Assessment completed within 2 days of admission. · Any change in resident condition will result in a new Hot Liquid Risk Assessment completed by the DON, ADON, or nurse on duty. · All new admissions and residents with significant changes related to hot liquid safety will be reviewed through the QAPI program for ongoing monitoring and system improvement by DON/ADON or designee. Monitoring Process: · Audits will be conducted weekly x 4 weeks on 10 residents (random), · then monthly x 3 months on ten residents · then quarterly x 2 quarters on three residents		
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F0600			

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F0600 SS = G	Continued from page 17 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on the South Dakota Department of Health (SD DOH) Facility Reported Incident (FRI), interview, record review, and policy review, the facility failed to protect one of one resident's (13) right to be free from physical abuse by contracted travel certified nursing assistant (CNA) BB who used physical force while providing care to resident 13 who subsequently had a skin tear and bruising to her arms. Findings include: 1. Review of the provider's 2/25/26 SD DOH FRI revealed on 2/24/26, at around 6:00 a.m., an unidentified CNA entered resident 13's room to assist her with her morning care. The CNA noted that resident 13 had bruises on both her arms and a skin tear on her right arm. The CNA reported her findings to the on-duty contracted travel registered nurse (RN) T. The nurse assessed resident 13 and confirmed that she had bruises on both arms and a skin tear on her right arm. Resident 13 told the CNA and RN that a girl from the night shift was mean, grabbed her arm, and wanted her to get out of bed to go to the bathroom. Resident 13 told the staff member no and said she had already gone to the bathroom, but the staff member made her get up out of bed. The incident, along with resident 13's bruising and skin tear, was reported to director of nursing (DON) B when she arrived at work that same day. On the evening of 2/24/26, DON B and the chief executive officer (CEO) A met with contracted travel CNA BB, to discuss resident 13's abuse allegation. Contracted travel CNA BB explained that she was assisting resident 13 in getting ready for bed on the evening of 2/23/26. While helping resident 13 stand, resident 13 began to fall, contracted travel CNA BB grabbed resident 13 by both forearms to steady her, which may have caused the bruising.	F0600		

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F0600 SS = G	Continued from page 18 When contracted travel CNA BB went in to assist resident 13 with care early the next morning on 2/24/26, resident 13 was combative, but contracted travel CNA BB said she was able to reason with resident 13 and left her room when resident 13 told her to. Contracted travel CNA BB wrote a statement about the incident and was placed on administrative leave pending the investigation. CEO A and DON B interviewed resident 13 regarding her allegation following the meeting held with contracted travel CNA BB, and resident 13's account of the incident did not differ from her previous explanations. DON B said that a witness statement was obtained by the unidentified CNA, which documented the bruising and skin tear on resident 13's arms the morning of 2/24/26. The unidentified CNA's witness statement was provided by DON B for review and revealed that the unidentified CNA's findings were written on a sheet of paper that contained no date or signature and contained another witness statement from an unidentified staff member with no date or signature. The statement for the unidentified CNA explained the findings regarding resident 13's bruising and skin tear on the morning of 2/24/26, and the statement by an unidentified staff member explained resident 13's mood and behavior from the previous evening, 2/23/26. Law Enforcement was notified by the facility on 2/25/26 at approximately 9:30 a.m. about the abuse allegation and began an investigation. The investigation's conclusion indicated that CNA BB's contracted travel employment at the facility was terminated on 2/25/26, and her travel employment agency was notified that she was no longer permitted on the facility's premises. Resident 13's power of attorney (POA, a trusted person to act on your behalf regarding financial, legal, or medical matters), DON, administrator, and physician were notified of resident 13's injuries and the investigation. The Department of Human Services (DHS) and the SD DOH were both notified on 2/25/26. 2. On 5/26/26, a request for the facility's investigation documentation for 2/25/26 was made, and on 5/27/26 at 8:12 a.m., CEO A reported that	F0600	Investigation Process Includes: • Interviews (resident, staff, witnesses, others as appropriate) • Record review (medical record, care plan, CNA documentation, incident reports, staffing assignments) • Environmental review (location, equipment, safety risks) • Evidence collection (photos, statements, physical evidence as applicable) Documentation: • All findings documented on the Investigation Report Form • Includes timeline, interview summaries, evidence, and conclusions Conclusion: • Determination of substantiated, unsubstantiated, or inconclusive • Final report completed within 5 working days (or per state requirement) Corrective Actions: • Staff education/retraining • Disciplinary action up to termination • Care plan updates • Environmental modifications Reporting of Results: • Final report submitted to State Agency, Administrator, and QAPI Committee • Resident and/or responsible party notified as appropriate QAPI Integration: • All investigations reviewed through QAPI • Trends tracked and analyzed • Performance improvement plans implemented as needed Staff will be educated on the updated policy and process by July 9, 2026		07/09/2026

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F0600 SS = G	Continued from page 19 the facility did not have any investigation documentation to provide. 3. Review of resident 13's electronic medical record (EMR) revealed she admitted to the facility on 7/10/25. Her 12/30/25 Brief Interview of Mental Status (BIMS) assessment score was 4, and her 3/24/26 BIMS assessment score was 7, both of which indicated her cognition was severely impaired. Resident 13 was discharged on 4/2/26 due to her death in the facility. A 2/24/26 6:35 a.m. nursing progress note documented by contracted travel RN T revealed that "staff reported to this writer that resident [13] had 3 large purple bruises on the right forearm." "The bruise closest to the wrist has a small skin tear." "One purple bruise on [the] left forearm." "Left side of lip has a small cut." "Resident states, 'She grabbed my arm and twisted it.' "DON, ADON [assistant DON] notified." Resident 13's 2/24/26 12:57 p.m. skin assessment indicated that she had "3 large purple bruises on her right forearm." "The bruise closest to the wrist has a small skin tear." "One purple bruise on her left forearm, and the left side of her lip has a small cut." "Denies having pain, Turgor [the skin's elasticity used to check the body's hydration level] is > [greater than] 3 seconds." A 2/24/26 3:37 p.m. progress note indicated that contracted travel RN T was unable to reach resident 13's first emergency contact person but was able to reach her second emergency contact person by phone, and he would try to notify resident 13's first emergency contact person. A 2/25/26 1:16 p.m. progress note indicated that DON B attempted to call resident 13's first emergency contact to "Follow up on [her] bruises", "No answer, will try again later." There was no other documentation in resident 13's EMR that indicated resident 13's first emergency contact was notified of the abuse allegation on 2/24/26 that resulted in physical harm. A 3/8/26 physician's order indicated to "observe bruising to bilateral forearms until healed, two times a day."	F0600	Monitoring will include an audit to ensure the: • Weekly audits x 4 weeks • Monthly audits x 3 months • Quarterly audits x 2 quarters Audits will review: • Timeliness of reporting • Completion of investigations • Documentation accuracy • Staff compliance with policy Results will be reviewed in QAPI, and corrective action will be taken as needed. Education will be completed about State reporting and investigation with staff by 07/09/2026. Audits will be done by Administrator/DON or designee on all State reports, and the audits will be ongoing every time there is a State reportable. All investigations will be kept with each State report.	

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F0600 SS = G	Continued from page 20 Review of resident 13's most recent care conference summary was completed on 3/25/26, but no care conference signature form was available to review. There was no documentation in resident 13's EMR that the allegation of abuse with physical harm was reviewed with her family and the IDT team. Resident 13's care plan, dated 7/10/25 and revised on 3/30/26, did not address interventions that helped ensure her safety from abuse related to her cognitive or behavioral status. Incident tracking reports in the facility's electronic system (PCC) showed that no incident report for the abuse incident had been completed in the risk management report section from 2/16/26 through 3/16/26, as required by the facility's policy. 4. Review of the facility's staff schedules and timecards from 2/23/26 through 2/24/26 revealed that contracted travel CNA BB was assigned to resident 13 during the night shift on 2/23/26 at 5:17 p.m. through the morning of 2/24/26 at 6:21 a.m. 5. Review of contracted travel CNA BB's personnel file revealed that she was hired in January 2024 through a contracted travel agency. She completed abuse training through another facility on 4/13/23 and elder physical abuse and managing resident behaviors training with the provider on 9/8/25. No disciplinary actions or allegations of abuse and neglect were documented or found in former contracted travel CNA BB's file. 6. Interview on 5/27/26 at 3:37 p.m. with licensed social worker (LSW) E revealed the incident reports were completed by CEO A and DON B, and that she was not aware of resident 13's allegation of abuse on 2/24/26. LSW E did not believe she was notified of the incident involving resident 13 on 2/24/26 and acknowledged that she did not complete any documentation regarding the incident in resident 13's EMR. 7. Phone interview with resident 13's first emergency contact was attempted on 5/27/26 at 4:08 p.m.; a message was left for a return call. No return call was received during the survey. 8. Interview on 5/28/26 at 4:50 p.m. with CEO A revealed that CEO A acknowledged that no audits or	F0600			

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F0600 SS = G	Continued from page 21 education were provided to staff regarding resident abuse, and that no further follow-up was conducted with other residents to determine whether they were harmed by staff or felt safe at the facility. He said that resident incidents were routinely discussed in the Quality Assurance Performance Improvement (QAPI) and board meetings, and did not provide any further information on what those meetings determined regarding the incidents. 9. Interview on 6/1/26 at 12:08 p.m. with DON B revealed that she or CEO A initiated incident investigations. DON B acknowledged that no other residents were interviewed as a part of their investigation to assess additional concerns of abuse or neglect, no additional education on abuse prevention was provided to staff, and no audits related to the resident interviews and staff education were completed after the 2/24/26 incident involving resident 13. DON B further stated that approximately two weeks prior to resident 13's abuse allegation, she spoke to contracted travel CNA BB about toileting residents upon their requests, as it had been reported to her by staff that contracted travel CNA BB had told a resident, whom DON B could not recall, that she could not use the bathroom. DON B said she spoke with contracted travel CNA BB about that allegation, and contracted travel CNA BB denied it. DON B said she reported the information to the contracted travel CNA BB's travel staffing company to inform them that the discussion about the resident's situation had been identified as a disciplinary matter involving contracted travel CNA BB. 10. Review of the provider's revised June 2021 job description for the long-term care (LTC) Certified Nurse Assistant (CNA) revealed that "The CNA assists in the provision of nursing care of the residents as directed by the charge nurse. Care skills include but are not limited to: comfort and safety measures, personal hygiene, assisting with activities of daily living, and simple nursing procedures." The CNA's duties include: "Assisting residents with activities of daily living (ADLs) such as bathing, dressing, and grooming, responding to patient call lights and anticipating resident needs, maintaining a safe and orderly environment, following established health and safety standards, and coordinating with			F0600			

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F0600 SS = G	Continued from page 22 nurses and other healthcare professionals to ensure comprehensive and consistent patient care." CNAs will "Demonstrate knowledge of the principles of growth and development over the life span and the skills necessary to provide age-appropriate care." "Demonstrate appropriate lifting, repositioning, and moving of residents." "Reports resident concerns, and promotes a safe and hazard-free resident care environment." 11. Review of the provider's reviewed December 2021 Abuse Prohibition policy revealed that the facility was "To utilize the abuse prohibition investigative protocol to be in compliance with federal regulations." "Documentation is required for all suspicious injuries, bruises, skin tears, fractures, and injuries of unknown origin." "The primary RN or DON will complete necessary documentation surrounding the injury using the Injury Assessment form." "Abuse, involuntary seclusion, and misappropriation of property will be reported to the primary registered nurse (RN) and then to the director of nursing (DON) or social worker who will be responsible for initial investigation of the incident." "Document the investigation by using the Grievance Complaint Investigation form, and place it with the investigation report." 12. Review of the undated admission packet revealed that "The facility will notify the resident or representative when an accident or injury occurs." "Complaints of abuse, harassment, or mistreatment will be immediately investigated and you [the resident or resident's representative] will receive a written and/or verbal report of the findings, and/or corrective actions taken within five working days of filing the report."	F0600			
F0835 SS = F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is NOT MET as evidenced by:	F0835	Residents identified as being affected by ineffective administrative oversight were immediately reviewed by the Administrator, Director of Nursing (DON) and Assistant DON (ADON) - Psychotropic consents were created - Consent from resident or POA was received on all residents, completed on 6/26/2026 - Hot liquid assessment was created and will be completed on all residents by 7/9/2026	07/09/2026	

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F0835 SS = F	Continued from page 23 Based on observation, interview, record review, and policy review, the provider failed to ensure the facility was operated and administered by chief executive officer (CEO) A and director of nursing (DON) B in a manner that ensured quality of life and overall well-being for all 26 residents in the facility. Findings include: 1. Observations, interviews, record reviews, and policy reviews throughout the survey from 5/26/26 through 5/28/26 and 6/1/26 through 6/2/26 revealed CEO A and DON B did not ensure the management, safety, quality of life, and overall well-being of all the residents who lived at the facility. Those were evidenced by a widespread system breakdown to ensure services provided met professional standards and the minimum requirements as it pertained to providing education to residents and residents' representatives to be able to make informed decisions regarding psychotropic medication use, the filing of grievances, the residents' right to be free from abuse and neglect, the right to be free from chemical restraints, investigating and reporting allegations to the South Dakota Department of Health within the required timeframe, resident baseline care plans (personalized plan that addresses a resident's care needs, goals, and interventions within the first 48 hours of admission) completed and offered to the resident or their representative, the updating of care plans to reflect the residents' current care needs, accident hazards identification and mitigation related to entrapment risks for bed side rail use and hot liquid injury, the timeliness of physician visits and complete documentation of the visit, the accountability and securement of controlled medications (medications with risk for abuse and addiction), the pharmacist's medication regimen review, medication accessibility, the removal of expired supplies from use, staff training, and a functioning and effective QAPI (quality assurance and performance improvement) program. 2. Interview on 6/2/26 at 12:31 p.m. with CEO A revealed he had worked at the facility since 6/29/23. He was the CEO for the long-term care facility, the clinic, and the attached hospital. He confirmed he was responsible for the daily operations of the facility. 3. Review of the providers undated CEO job description revealed, "The Chief Executive Officer (CEO) will be responsible for overall administrative	F0835	- Hot liquid policy was created on 6/25/26 and education will be completed on all residents by 7/9/26. - Care plans will be reviewed and updated to reflect current needs, by 7/9/2026 - Staff involved received education on abuse and Neglect on 6/26/2026 - Incident and disease reporting education was developed and education will be completed by 7/9/2026 A facility-wide audit will be conducted to identify any additional residents potentially affected by ineffective administrative oversight. This included review of: - Care plans - Physician orders - Incident/accident reports - Timeliness of assessments and interventions Any concerns identified were addressed immediately, with appropriate interventions implemented. This to be completed by 7/9/2026 The facility has implemented the following systemic changes: - The Administrator and DON will conduct routine interdisciplinary team (IDT) meetings to ensure coordination and oversight of resident care. - o High-risk residents - o Incidents/accidents - o Changes in condition - A QAPI monitoring system has been strengthened to ensure: - o Trends are identified - o Corrective actions are implemented timely - Policies and procedures related to administrative oversight were reviewed and updated as needed. Monitoring will include: - Weekly audits x 4 weeks, then - Monthly audits x 3 months, then - Quarterly audits x 2 quarters	

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F0835 SS = F	Continued from page 24 management and operation of the hospital, clinics, long-term care program, and related entities under the health umbrella in [redacted name of the town]...Leads in educational programs, participates as a teacher and preceptor. Monitors the adequacy and quality of the hospital, clinic, and long-term care medical activities through coordination with the board, management partners [with] the medical and nursing staffs, and enacts policies to assure excellent health care services." 4. Review of the provider's undated director of nursing job description revealed "The DON plans, organizes, develops, and directs the overall operation of the LTC [long-term care] Nursing Department. Works closely with the Medical Director, and interdisciplinary teams to ensure that a high degree of quality care is maintained in accordance with current federal and state guidance and regulations as well as established policies and procedures." Refer to F552, F585, F600, F605, F609, F655, F657, F689, F700, F712, F755, F756, F761, F865, F944, and F947.	F0835	Audits will include review of: · Timeliness of assessments and care plan updates · Incident/accident follow-up · IDT meeting documentation · QAPI tracking and follow-through Results will be reviewed in QAPI meetings, and: · Any identified issues will result in immediate corrective action · Additional staff education will be provided as needed · Monitoring frequency may be increased based on findings	7/9/2026
F0865 SS = F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;	F0865	F0865 A new LTC QAPI plan was completed and updated to meet the needed requirements. Changes include The QAPI Program is an ongoing, data-driven program designed to: · Monitor and improve quality of care and quality of life for residents · Identify areas of improvement proactively · Implement corrective actions and sustain improvements · Ensure compliance with federal and state regulations This program applies to all departments, services, and staff, including contracted providers.	

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F0865 SS = F	Continued from page 25 §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.	F0865	The facility is committed to: · Resident-centered care · Continuous quality improvement · System-based problem solving · Data-driven decision making · Interdisciplinary team collaboration QAPI Governance & Structure QAPI Committee Composition · Administrator (Chair) · Director of Nursing (DON) · Assistant Director of Nursing (ADON) · Medical Director · Infection Preventionist · Quality Coordinator / QAPI Lead · Department Heads (Dietary, Therapy, Social Services, Activities, Maintenance) · Front line staff (as applicable) Meeting Frequency · Quarterly QAPI meetings · Additional meetings for active projects as needed QAPI will monitor clinical care, quality of life, resident satisfaction (resident council) and operational processes The facility collects and will analyzes data from multiple sources including but not limited to: · Incident/accident reports · Infection logs · CMS Quality Measures (QMs) · Survey results and deficiencies · Grievances and complaints PIP process will include: · Identify problem · Develop action plan · Implement interventions · Measure outcomes · Sustain improvements				

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F0865 SS = F	Continued from page 26 §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure they identified, investigated, and corrected quality deficiencies, and to initiate or monitor performance improvement projects (PIPs) in response to known areas of concern within their Quality Assurance and Performance Improvement (QAPI) program. Findings include: 1. Interview on 5/28/26 at 5:00 p.m. with CEO A revealed that director of nursing (DON) B managed the facility's QAPI program. He did not routinely attend the long-term care (LTC) QAPI meetings because he "was not required" to be present. He received a copy of the LTC QAPI meeting minutes	F0865	QAPI program will be reviewed annually. Take to the Board of Directors quarterly.				

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F0865 SS = F	Continued from page 27 and provided that at the general QAPI meeting and again at the board meetings, where he reviewed them. Medical director L was a member of the LTC QAPI committee, attended the meetings when he was able to, and was involved in the policy and procedure process as much as his time allowed. 2. Interview on 6/2/26 at 10:01 a.m. with medical director L revealed that he attended the facility's QAPI meetings quarterly (meaning occurring every three months) when he was able. If he was not able to attend in person, he would attend online. He received a copy of the meeting minutes for review every quarter. 3. Interview on 6/2/26 at 11:48 a.m. with DON B revealed that she was the QAPI Manager and led the QAPI meetings. The facility held quarterly QAPI meetings with committee members, and each committee member was expected to attend and present a report on the information they monitored. She tracked the committee members' attendance. The attendance tracker included the committee member's name, a column for "Yes" (meaning in attendance), and "No" (meaning did not attend). She placed a checkmark in the "Yes" column if the member attended, and a checkmark in the "No" column if the member did not attend. The QAPI committee implemented PIPs, and the staff were informed of them by their department managers. She acknowledged that potentially harmful systemic issues and concerns were not identified or corrected since the last survey. The staff did not receive training on the elements and goals of the facility's QAPI program. 4. Review of the provider's QAPI meeting attendance records revealed that on 11/23/25 and 3/24/26, CEO A and medical director L did not attend, and there were no other governing board members or facility owner present. On 1/27/26, the attendance record did not have any committee members marked as attending. 5. Review of the provider's QAPI documentation and meeting minutes revealed no PIPs were implemented to address concerns regarding resident safety and quality of care. 6. Interviews throughout the survey confirmed that the QAPI committee did not review or act on the problems that resulted in citations under F600, F605, F609, F689, F700, F755, and F761. There was no evidence that the facility collected safety data, conducted root cause analyses, or monitored	F0865		

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F0865 SS = F	Continued from page 28 corrective actions for the known issues. 7. Review of the provider's undated Chief Executive Officer (CEO) job description revealed that the CEO "Leads in educational programs, monitors the adequacy and quality of the medical activities through coordination with the board, management partners, the medical and nursing staff, and enacts policies to assure excellent health care services." "Ensures compliance with the regulations and the rules of accrediting bodies by continually monitoring the organization's service delivery and initiating changes as required." "Communicates with staff and volunteers to improve service." 8. Review of the provider's revised June 2021 Director of Nursing (DON), Long Term Care (LTC) job description revealed that the "DON plans, organizes, develops, and directs the overall operation of the LTC Nursing Department and works closely with the Medical Director, and interdisciplinary team to assure that a high degree of quality care is maintained in accordance with current federal and state guidelines and regulations as well as established policies and procedures of [Facility Name Redacted]." "The DON has a primary role in the evaluation and improvement of nursing and other services provided. Provides effective onboarding, education, and training to assure staff competencies, and provides ongoing coaching, mentoring, and performance feedback for staff to succeed." 9. Review of the provider's reviewed October 2025 LTC Quality Assessment Performance Improvement (QAPI) Plan revealed that "The QAPI Plan is designed to evaluate, improve, monitor, and measure every activity at [Redacted Facility Name] that affects resident care. The results should be measurable improvement in resident care and optimal utilization of [Redacted Facility Name] LTC Resources." Some goals included, "Monitor and continuously improve resident care, find and correct problems in clinical care, improve resident and family satisfaction with services, provide education for staff on quality initiatives and their role, and assure accuracy of resident care documentation." The objectives included, "Involve all departments in QAPI activities," and "Document QAPI activities in departmental and committee meetings." The "LTC QAPI shall be composed of the Administrator [CEO], Director of Nursing [DON], Medical Director (as available), LTC IDT, QAPI			F0865			

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F0865 SS = F	Continued from page 29 Manager, and Pharmacist." "The Administrator [CEO] or Director of Nursing will ensure that assigned members of the medical and professional staff participate in the QAPI program and that recommendations for improvement from reports to the LTC QAPI Committee are implemented." "The committee shall meet quarterly (more if needed) and shall be responsible for: Reviewing QAPI activities for adequacy and timely completion, Receiving and acting on the quarterly QAPI reports prepared by the QAPI Manager, Identifying opportunities for improvement; implementing initiatives to address problems and documenting follow-up and resolution of problems." "The QAPI Manager shall report to the Director of Operations, attend all QAPI Committee meetings, and review reports of various activities." "These reports include: quality indicator profiles, resident council, family council, pharmacy drug regimen reviews, family satisfaction surveys, resident abuse files, and incident reports." "The QAPI Manager shall perform concurrent monitoring activities of the following: medication records, treatment sheets, incident reports, medication errors, and 24-hour nursing reports." "The QAPI Manager will maintain records of all concurrent monitoring activities." "Problems affecting resident care are brought to the attention of the QAPI Manager through safety reports, incident reports, survey reports, and resident council minutes." "Data will be collected and recorded so that the degree of compliance with achievable goals can be measured." "When the cause and scope of a problem are known, corrective action shall be implemented." "Alternatives for corrective action include, but are not limited to: In-service Educational Problems, New or Revised Policies and Procedures, Staffing Changes, and Equipment or Facility Change." "The QAPI Committee shall assign problem reassessment and monitoring responsibilities to determine if problems have been resolved or reduced to an acceptable level, and activities shall be documented and should demonstrate measurable improvement in quality of resident care." Refer to F600, F605, F609, F689, F700, F755, and F761.	F0865		

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F0552 SS = E	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. 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 ensure 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 the consent for the use of psychotropic medications (drugs that affects brain activities associated with mental processes and behavior) before they were administered to four of four sampled residents (3, 6, 21, and 32). Findings Include: 1. Review of resident 21's EMR revealed he admitted to the facility on 10/23/25. His 4/21/26 BIMS assessment score was 3, 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), dementia with agitation and behavioral disturbance, and neurocognitive disorder with Lewy Bodies (a progressive brain disorder caused by abnormal protein clumps that damage nerve cells that affects thinking, memory, movement, sleep, and behavior), and obstructive sleep apnea (a disorder when your breathing repeatedly stops and starts during sleep	F0552	The identified resident(s) receiving psychotropic medication were immediately reviewed to ensure: • Informed consent was obtained from the resident and/or responsible party • Risks, benefits, alternatives, and the right to refuse were explained • Each psychotropic medication will have diagnosis/clinical indication supporting its use this will be completed by 7/15/2026 Missing or incomplete consent documentation was obtained and completed on 6/26/2026. The attending physician was notified, and medication orders were reviewed for ongoing appropriateness to be completed by 7/15/2026. Care plans will be updated to reflect: • Use of the psychotropic medication • Appropriate diagnosis/clinical indication for each medication • Consent status • Non-pharmacological interventions An audit of all residents receiving psychotropic medications was conducted to verify: • Presence of signed informed consent • Documentation of discussion of risks, benefits, and alternatives • Evidence of attempted non-pharmacological interventions Any identified gaps were corrected immediately, including obtaining consent and updating documentation. The facility developed and implemented an Informed Consent for Psychotropic Medications Policy, which includes: • Required elements (risks, benefits, alternatives, right to refuse) • Required time frames (prior to initiation and with significant changes) • Documentation standards • Requirement that each psychotropic medication must have a documented diagnosis/clinical indication	07/09/2026

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F0552 SS = E	Continued from page 31 because the throat muscles relax, causing the airway to collapse and block airflow). He had a 10/23/25 physician's order to be given one tablet of 15 mg temazepam, a sedative-hypnotic medication that helps the brain relax, making it easier to fall asleep, by mouth every 24 hours as needed at bedtime for insomnia. No documentation indicated that the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or provided their consent for that medication to be administered to resident 21. He had a 10/23/25 physician's order for trazodone 100 mg (an antidepressant medication), one tablet by mouth at bedtime for insomnia. No documentation indicated that the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or provided their consent for that medication to be administered to resident 21. He had 10/24/25 physicians' orders to be given 0.25 ml of lorazepam Intensol oral concentrate, an antianxiety medication, by mouth every two hours PRN for agitation and to be given 0.5 ml of lorazepam by mouth every two hours PRN for agitation. No documentation indicated that the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or provided their consent for that medication to be administered to resident 21. Licensed pharmacist M reviewed resident 21's chart and medication list on 1/26/26, and suggested his lorazepam orders be evaluated by his physician. Licensed pharmacist M indicated in a 5/29/26 review note that resident 21's lorazepam was discontinued by the physician. A 1/30/26 order note for resident 21 indicated that a physician's order was received to discontinue his lorazepam. Review of resident 21's active physician orders indicated that resident 21 continued to be administered his 0.25 ml and 0.5 ml lorazepam Intensol oral concentrate PRN doses as ordered by the physician on 10/24/25. No documentation indicated that the lorazepam doses were ordered to be discontinued on 1/30/26.	F0552	The DON, ADON, or designee will be responsible for ensuring consent is obtained and properly documented. Staff will be educated on informed consent requirements and the new policy by 7/9/2026. New residents will be seen 14 days by a provider within 14 days to determine if there is a need. Psychotropic medication will be addressed at IDT at least two days a week. DON/Administrator/ADON or designee will be responsible for getting consent/risk vs benefits from resident or family prior to administration. Monitoring will include: • Weekly audits x 4 weeks - all psychotropic PRN meds • Monthly audits x 3 months - all psychotropic PRN meds • Quarterly audits x 2 quarters - all psychotropic PRN meds Audits will include review of: • Presence of informed consent • Documentation of risk/benefit discussions • Care plan accuracy • Use of non-pharmacological interventions Results will be reviewed in QAPI, and corrective action will be taken as needed.	

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F0552 SS = E	Continued from page 32 He had 3/6/26 physicians' orders to be given 1.5 tablets of 1 mg Risperdal, an antipsychotic medication, by mouth in the morning for agitation and 2 mg by mouth every 24 hours PRN, that may be given at bedtime for agitation or anxiety. No documentation indicated that the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or provided their consent for that medication to be administered to resident 21. He had 4/2/26 physicians' orders to be given one tablet of 100 mg (1 tablet) sertraline, an antidepressant medication, by mouth in the morning and 50 mg (one-half tablet) at bedtime for depression. No documentation indicated that the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or provided their consent for that medication to be administered to resident 21. He did not have a diagnosis of depression (a mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities). 2. Review of resident 6's EMR revealed he admitted to the facility on 11/17/25. His 5/14/26 BIMS assessment score was 5, which indicated his cognition was severely impaired. He did not have a diagnosis of schizophrenia (a chronic and severe brain disorder that affects how a person thinks, feels, and acts), bipolar disorder (a mental health condition characterized by extreme, recurring shifts in mood, energy, and activity levels), anxiety, depression (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities), or a severe behavioral disorder. He had an 11/13/25 physician's order for Sertraline HCl oral tablet 100 mg to be administered by mouth in the morning for depression. No documentation indicated that the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 6. He had a 1/23/26 physician's order for Haldol 5 mg (an antipsychotic medication; a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions) "give 10 mg by mouth every 6 hours as needed for agitation."			F0552			

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F0552 SS = E	Continued from page 33 That physician's order did not have an end date, a diagnosis for use, and resident 6 needed to be seen by a physician to have that medication reordered on 2/8/26. No documentation indicated that the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 6. He had a 2/20/26 physician's order for Seroquel 25 mg (an antipsychotic medication), one tablet to be administered by mouth two times a day for agitation. The behaviors that Seroquel was ordered to treat were not identified. There was no diagnosis for use identified for that medication. 3. Review of resident 3's EMR revealed she admitted to the facility on 12/12/24. Her BIMS assessment score was 11, which indicated her cognition was moderately impaired. Her diagnoses included anxiety disorder and dementia with behavioral disturbance. She had a 7/29/25 physician's order for alprazolam 0.5 mg (an anti-anxiety medication), one tablet to be administered as needed for anxiety. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 3. She had a 5/23/25 physician's order for escitalopram 20 mg (an antidepressant medication), one tablet to be administered every morning for anxiety. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 3. She had a 12/23/25 physician's order for haloperidol 5 mg one tablet to be administered as needed for agitation. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 3. She had a 12/23/25 physician's order for Seroquel 50 mg, one tablet to be administered at bedtime for behaviors. No documentation indicated that the	F0552		

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F0552 SS = E	Continued from page 34 resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 3. She had an 8/7/25 physician's order for trazadone 50 mg, one tablet to be administered at bedtime for sleep. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 3. 4. Review of resident 32's EMR revealed she admitted to the facility on 4/16/26. Her 4/22/26 BIMS assessment score was 14, which indicated her cognition was intact. Her diagnoses included dementia with agitation. She had a 4/17/26 physician's order for lorazepam 1 mg (an anti-anxiety medication), one tablet to be administered every eight hours as needed for anxiety. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 32. She had a 4/21/26 physician's order for lorazepam 1 mg, one tablet to be administered two times per day. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 32. She had a 4/16/26 physician's order for mirtazapine 7.5 mg (an antidepressant medication), one tablet to be administered at bedtime for depression. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 32. She had a 4/25/26 physician's order for quetiapine 50 mg (an antipsychotic medication), one tablet to be administered in the afternoon for agitation and dementia with behaviors. No documentation	F0552		

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F0552 SS = E	Continued from page 35 indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided consent for that medication to be administered to resident 32. She had a 4/21/26 physician's order for olanzapine 10 mg (an antipsychotic medication), one tablet to be administered two times per day for dementia with agitation. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 32. 5. Interview and EMR review on 6/2/26 at 11:30 a.m. with director of nursing (DON) B revealed the provider did not review the risk versus benefit, educate on alternatives to the psychotropic medications, or have consent forms signed by the resident or the resident's representative before starting or changing resident 21's psychotropic medications. The provider did not have a policy related to psychotropic medications. There was no documentation that resident 21's representative was notified when resident 21 was started on his psychotropic medications. There was no documentation that resident 32's representative was notified when she was started on the lorazepam as needed for anxiety, the mirtazapine, or the quetiapine, because he was difficult to reach by phone. DON B was aware of the regulation related to obtaining the residents' or the residents' representatives' consent for the use of psychotropic medications, but did not implement a process for the review of risks versus benefits, review of alternative treatments or interventions, and obtaining consent for psychotropic medications. 6. Interview on 6/1/26 at 2:33 p.m. with licensed pharmacist M revealed she expected the resident or the resident's representative to be informed of the risks versus benefits of taking a psychotropic medication before the medication was administered or changed. When she made a recommendation, she sent a copy to the resident's physician and DON B. If the physician did not address her recommendation, she did not include it in the following month's review, since she had already mentioned it. Licensed pharmacist M reviewed	F0552					

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F0552 SS = E	Continued from page 36 medication-related diagnoses to ensure that medications had appropriate diagnoses. She acknowledged that residents 21 and 32 did not have a diagnosis for depression but were being treated with an antidepressant. 7. Interview on 6/2/26 at 10:01 a.m. with medical director L revealed that he received resident recommendations from the pharmacist after she reviewed resident charts for gradual dose reductions (GDRs) and monthly medication reviews (MMRs). He reviewed and discussed them with the pharmacist, then submitted an electronic prescription reflecting the changes. Medical director L expected that if he failed to respond to a GDR recommendation, licensed pharmacist M, DON B, or assistant DON C would address him in person immediately. Both the nursing staff and the pharmacist should review the GDRs and MMRs to ensure the orders and reviews were complete. If a medication lacked a diagnosis, he expected the nurse to address the missing diagnosis with their supervisor to obtain the appropriate diagnosis. 8. Interview on 6/2/26 at 12:31 p.m. with chief executive officer (CEO) A revealed he was aware that consent forms were not being completed for psychotropic medications, and that appropriate diagnoses were not documented for resident medications. He was unaware that licensed pharmacist M's recommendations were not reaching medical director L, and, as a result, the provider did not implement them for several months. He acknowledged that pharmacy recommendations regarding psychotropic medication management were not implemented promptly, and residents or their representatives were not informed about their psychotropic medication treatment, including risks, benefits, alternatives, and providing their consent before initiation or continuation of the resident's medications. 9. Review of the provider's 1/12/26 Behavioral Health Management policy revealed, "Staff will proactively assess, monitor, and manage behavioral symptoms using individualized, nonpharmacological and clinically appropriate interventions while ensuring resident dignity, safety, and regulatory compliance." The resident's family was to be notified of significant behavioral changes. Residents have the right to participate in care decisions (as able).			F0552			

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F0605 SS = E	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- . . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F0605	Immediate corrective actions were taken for residents identified during the survey: - Resident 9: Ativan and Haldol were discontinued and not reordered. - Resident 3: Haldol and Lorazepam were discontinued and not reordered. Care plan will be reviewed and updated by 7/9/2026 by MDS Consultants, DON, and/or ADON. - Resident 21: PRN medications (Risperdal, Lorazepam, Morphine, and Temazepam) were discontinued. - Resident 6: Haldol was discontinued. - Resident 32: MDS Consultants, DON, ADON, or designee will review and update the care plan. - A facility-wide review was conducted to identify all residents receiving PRN or scheduled psychotropic medications. - All identified residents were assessed for appropriate use, indication, and necessity of medications. - Any medications not clinically indicated or not utilized were discontinued in collaboration with the attending provider. - A Medication Management and Review Policy was developed and implemented, addressing: - Monthly Drug Regimen Reviews by the consultant pharmacist. - Safe medication storage and security - Requirements for PRN psychotropic medications, including: - Mandatory 14-day stop dates - Required reevaluation prior to continuation - Psychotropic Medication Consent Process: - Informed consent was initiated for all residents receiving PRN or scheduled psychotropic medications. - Consent includes risks, benefits, and alternatives. - All residents (or responsible parties) were educated, and consents were completed by 6/27/2026.	7/9/2026

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F0605 SS = E	Continued from page 38 (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or	F0605	Family/Responsible Party Communication: –Families of Residents 9, 3, 21, and 6 were educated that PRN psychotropic medications were not being utilized and were therefore discontinued. –Family of Resident 32 was educated regarding the need for a new physician order due to frequent use of the medication. –Families expressed understanding and, in some cases, requested no additional medication changes at this time. Care Plan Review: – MDS Consultants, DON, ADON, and/or designee will complete a comprehensive review of all resident care plans. - This review will include: –Verification of appropriate diagnoses –Review and update of interventions –Ensuring alignment between diagnoses, behaviors, and medication use –Inclusion of non-pharmacological interventions where appropriate. New residents will be seen 14 days by a provider within 14 days to determine if there is a need. Psychotropic medication will be addressed at IDT at least two days a week. DON/Administrator/ADON or designee will be responsible for getting consent/risk vs benefits from resident or family prior to administration. Monitoring will include: • Weekly audits x 4 weeks - all psychotropic PRN meds • Monthly audits x 3 months - all psychotropic PRN meds • Quarterly audits x 2 quarters - all psychotropic PRN meds	

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F0605 SS = E	Continued from page 39 she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the facility failed to protect the residents' rights to be free of unnecessary medications, specifically psychotropic medications (drugs that affect brain activities associated with mental processes and behavior), for five of five sampled residents (3, 6, 9, 21, and 32) who were administered psychotropic medications without usage order stop dates or documented reasoning for continuation of use of as needed psychotropic medications beyond fourteen days, completed risk versus benefit evaluations for informed consent for use, documented diagnoses for use, documented and physician responses to pharmacy recommendations. Findings include: 1. Review of resident 9's electronic medical record (EMR) revealed she admitted to the facility on 12/18/23. Her 2/27/26 Brief Interview of Mental Status (BIMS) assessment score was 3, which indicated her cognition was severely impaired. Her diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) with agitation. She had a 9/5/25 physician's order to be given 0.25 milliliters (mL) of lorazepam 2 milligrams per milliliter (mg/ml) (an anti-anxiety medication) every two hours as needed (PRN) for agitation or anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). The physician's order did not have a usage end date. Resident 9 did not have a diagnosis of anxiety. Her 5/27/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) did not indicate she had agitation or anxiety and did not identify any non-pharmacological (without medication) interventions to help her manage agitation or	F0605	Audits will include: --Appropriate use of psychotropic medications --Presence of informed consent --Documentation of indication and effectiveness --Compliance with 14-day PRN stop dates --Evidence that medications are not used as chemical restraints Audit results will be reviewed during QAPI meetings, and corrective actions will be implemented as needed. Education will be completed at a mandatory staff meeting by 7/9/2026.	

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F0605 SS = E	Continued from page 40 anxiety. 2. Review of resident 3's EMR revealed she admitted to the facility on 12/12/24. Her 5/15/26 BIMS assessment score was 11, which indicated her cognition was moderately impaired. Her diagnoses included anxiety disorder and dementia with behavioral disturbance. She had a 12/23/25 physician's order to be given one 5mg tablet of haloperidol (an antipsychotic medication that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions) as needed for agitation. The physician's order did not have a usage end date. She had a 12/23/25 physician's order to be given one tablet of 50 mg Seroquel, (an antipsychotic medication) at bedtime for behaviors. The behaviors that Seroquel was to treat were not identified in that order. Her 5/28/26 care plan had a focus area that indicated she received a psychotropic medication related to behavior management. That focus area did not identify what her behaviors were or non-pharmacological interventions for those behaviors. A focus area indicated she had hallucinations and took the antipsychotic medication olanzapine for anxiety, agitation, and psychosis (a state of losing touch with reality). There were no non-pharmacological interventions for the symptoms of hallucinations, anxiety, agitation, or psychosis. 3. Review of resident 21's electronic medical record (EMR) revealed he admitted to the facility on 10/23/25. His 4/21/26 BIMS assessment score was 3, 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), dementia with agitation and behavioral disturbance, and neurocognitive disorder with Lewy Bodies (a progressive brain disorder caused by abnormal protein clumps that damage nerve cells that affects thinking, memory, movement, sleep, and behavior), and obstructive sleep apnea (a disorder when your breathing repeatedly stops and starts during sleep because the throat muscles relax, causing the airway to collapse and block airflow). He had a 10/23/25 physician's order to be given	F0605					

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F0605 SS = E	Continued from page 41 one tablet of 15 mg temazepam, a sedative-hypnotic medication that helps the brain relax, making it easier to fall asleep, by mouth every 24 hours as needed at bedtime for insomnia. Resident 21's temazepam order did not indicate a 14-day stop date or include a physician's evaluation with a rationale for continuing the PRN temazepam beyond 14 days. He had 10/24/25 physicians' orders to be given 0.25 ml of lorazepam Intensol oral concentrate, an antianxiety medication, by mouth every two hours PRN for agitation and to be given 0.5 ml of lorazepam by mouth every two hours PRN for agitation. Those orders did not include 14-day stop dates or physician evaluations with rationales for continuing resident 21's lorazepam PRN doses beyond 14 days. Licensed pharmacist M reviewed resident 21's chart and medication list on 1/26/26 and suggested his lorazepam orders be evaluated by his physician. Licensed pharmacist M indicated in a 5/29/26 review note that resident 21's lorazepam was discontinued by the physician. A 1/30/26 order note for resident 21 indicated that a physician's order was received to discontinue his lorazepam. Review of resident 21's active physician orders indicated that resident 21 continued to be administered his 0.25 ml and 0.5 ml lorazepam Intensol oral concentrate PRN doses as ordered by the physician on 10/24/25. No documentation indicated that the lorazepam doses were ordered to be discontinued on 1/30/26. He had 3/6/26 physicians' orders to be given 1.5 tablets of 1 mg Risperdal, an antipsychotic medication, by mouth in the morning for agitation and 2 mg by mouth every 24 hours PRN, that may be given at bedtime for agitation or anxiety. Resident 21's Risperdal order did not indicate a 14-day stop date, and did not include an evaluation by the physician with a rationale to continue resident 21's PRN Risperdal beyond 14 days. He had a 4/2/26 physicians' orders to be given one tablet of 100 mg sertraline, an antidepressant medication, (1 tablet) by mouth in the morning and 50 mg (one-half tablet) at bedtime for depression. He did not have a diagnosis of depression (a mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities). 4. Review of resident 6's EMR revealed he admitted	F0605		

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F0605 SS = E	Continued from page 42 to the facility on 11/17/25. His 5/14/26 BIMS assessment score was 5, which indicated his cognition was severely impaired His diagnoses included type 2 diabetes mellitus, peripheral vascular disease (a circulation disorder characterized by the narrowing, blockage, or spasms of blood vessels outside of the heart and brain), chronic kidney disease (loss of the kidneys' ability to filter waste and excess fluid from the blood), cerebral infarction (stroke), repeated falls, weakness, and tremor (involuntary, rhythmic shaking or trembling movement). He had a 2/20/26 physician's order to be given one tablet of 25 mg Seroquel by mouth two times a day for agitation. He had a 1/23/26 physician's order to be given 10 mg of haloperidol by mouth every 6 hours as needed for agitation. That physician's order did not have an end date. He did not have a diagnosis of schizophrenia (a chronic and severe brain disorder that affects how a person thinks, feels, and acts), bipolar disorder (a mental health condition characterized by extreme, recurring shifts in mood, energy, and activity levels), anxiety, depression (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities), or a severe behavioral disorder, There was no documentation in resident 6's 5/20/26 care plan that he received an antidepressant or a psychotropic medication. There was a focus area that indicated that he "had a behavior of inappropriate touching to [of] female staff." There were no behavior-management or nonpharmacological interventions for those behaviors included in his care plan. 5. Review of resident 32's EMR revealed she admitted to the facility on 4/16/26. Her 4/22/26 BIMS assessment score was 14, which indicated her cognition was intact. Her diagnoses included dementia with agitation. She had a 4/16/26 physician's order to be given one tablet of 7.5 mg mirtazapine (an antidepressant medication) at bedtime for depression. Resident 32 did not have a diagnosis of depression. She had a 4/17/26 physician's order to be given one tablet of 1mg lorazepam every eight hours as needed for anxiety. There was no end date included	F0605			

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F0605 SS = E	Continued from page 43 for that PRN medication order. She had a 4/21/26 physician's order to be given one tablet of 1 mg lorazepam two times per day. There was no diagnosis or indication for use identified for that medication. She had a 4/21/26 physician's order to be given one tablet of 10 mg olanzapine two times per day for dementia with agitation and a 4/25/26 physician's order to be given one tablet of 50 mg quetiapine (an antipsychotic medication) administer one tablet in the afternoon for agitation. Olanzapine and quetiapine were in the same drug class. A 4/21/26 progress note from medical director L indicated he spoke with an on-call psychiatrist about resident 32's suicidal ideations who recommended "transitioning away from scheduled Seroquel (quetiapine) and switching to scheduled olanzapine." Her 5/28/26 care plan had a focus area of "uses psychotropic medications r/t [related to] depression, anxiety, and behavioral management." There were no non-pharmacological interventions identified for that focus area. Her care plan indicated she displayed "significant aggressive behaviors", and the intervention was for staff to provide one to one care for her if she poses a risk to herself or others. Potential triggers for her aggressive behavior were not identified. Her history of suicidal thought tiggers or interventions for those thoughts were not identified in her care plan. On 5/21/26, resident 32 had a 2:30 p.m. appointment with a mental health provider related to her prior suicidal thoughts. During that appointment, it was documented that she was, "unable to participate in the session due to being asleep and unresponsive to verbal prompting." Review of her May 2026 medication administration record (MAR) indicated that on 5/21/26 at 12:34 p.m. she was administered 5 mg of oxycodone (controlled pain medication with risk fir addiction and abuse) with a reported pain level of three and one tablet of lorazepam 1 mg for agitation. Resident 32 did not have any documented behaviors on 5/21/26. 6. Interview on 5/28/26 at 9:17 a.m. with registered nurse (RN)(space)Q revealed the nurses were to chart resident behaviors on the residents' MARs or treatment administration records (TAR). The certified nursing assistants (CNAs) would notify the nurse if a resident displayed a behavior. She did not know how the CNAs would know what behaviors the residents had or what the non-pharmacological interventions	F0605		

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F0605 SS = E	Continued from page 44 for those behaviors were. Some of the residents' behaviors and interventions were identified on their care plans, but others were not. 7. Interview on 6/1/26 at 2:33 p.m. with licensed pharmacist M revealed she reviewed the residents' medication regimens monthly. During her reviews, she looked for PRN psychotropic medication orders to check if those medication orders had an end date. If there were no end date, she would send a recommendation to the physician to order an end date for those medications. When she made a recommendation, she sent a copy to the physician and DON B. If the physician did not address her recommendation, she did not include it in the following month's review, since she had already mentioned it. She acknowledged resident 9's PRN lorazepam order did not have an end date. She stated resident 9 was on hospice services previously(, and that the medication order was a hospice order. Licensed pharmacist M was unaware of the regulation on end dates for hospice residents. She verified resident 9 was no longer receiving hospice services, but the medication remained on her medication list. She acknowledged haloperidol was an antipsychotic medication that was not to be ordered to be administered PRN for longer than 14 days without being seen and evaluated by a physician and obtaining a new physician's order for that medication. When she completed the residents' monthly medication reviews, she reviewed the medications for each diagnosis and the use of each medication. She did not review the residents' diagnosis list in the EMR to ensure that the diagnosis assigned to the medication was an active diagnosis for that resident. She verified resident 32 did not have an active diagnosis of depression(, but her physician's order for mirtazapine indicated it was being used for depression. Licensed pharmacist M was aware that resident 32 had duplicate antipsychotic medication therapy (define). She thought the duplicate therapy was the recommendation of the geriatric psychiatrist, according to medical director L's 4/21/26 progress note. After reviewing that progress note, she stated she previously read the progress note wrong, and medical director L indicated that resident 32 was to be transitioned from quetiapine to olanzapine. She	F0605			

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F0605 SS = E	Continued from page 45 did not recommend continuing that transition in her monthly medication review for resident 32. She acknowledged that resident 21 did not have a diagnosis for depression but was being treated with an antidepressant. 8. Interview on 6/2/26 at 10:01 a.m. with medical director L revealed that he received recommendations from the pharmacist after she reviewed resident charts for gradual dose reductions (GDRs) and monthly medication reviews (MMRs). He reviewed and discussed the recommendations with the pharmacist, then submitted an electronic prescription that reflected the medication changes. Medical director L expected that if he failed to respond to a GDR recommendation, licensed pharmacist M, director of nursing (DON) B, or assistant director of nursing (ADON) C would address that with him in person immediately. He stated that the nursing staff and the pharmacist should review the GDRs and MMRs to ensure the orders and reviews were completed. If a medication lacked a diagnosis, he expected the nurse to address the missing diagnosis with their supervisor to obtain the appropriate diagnosis from him. 9. Interview on 6/2/26 at 11:30 a.m. with DON B revealed the provider did not review the risk versus benefits, educate on alternatives to the psychotropic medications with the resident or the resident's representative, document that informed consent was obtained, or have written consent forms signed by the resident or the resident's representative before starting or changing resident 21's psychotropic medications. The provider did not have a policy related to psychotropic medications that addressed their use, risks, benefits, alternatives, non-pharmacological interventions, GDRs, PRN use limits, the ongoing need for the medications, and monitoring and safety. DON B acknowledged that there was no documentation that resident 21's representative was notified before he was started on his psychotropic medications. DON B did not implement a process for reviewing risks versus benefits, alternative treatments, or interventions, and obtaining informed or written consent from the resident or their representative for the use of psychotropic medications. 10. Review of the provider's 1/12/26 Behavioral Health Management policy revealed, "Staff will proactively assess, monitor, and manage behavioral symptoms using individualized, nonpharmacological	F0605		

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F0605 SS = E	Continued from page 46 and clinically appropriate interventions while ensuring resident dignity, safety, and regulatory compliance." "Each resident with behavioral health needs must have an individualized care plan addressing behaviors, identified triggers and early warning signs, specific interventions and staff approaches, and staff must prioritize non-drug approaches." The use of psychotropic medications, "Must comply with CMS [Center for Medicare and Medicaid Services] regulations (gradual dose reductions, indications)." "Use only when clinically necessary and not for staff convenience." Requires: Documented clinical indication, provider order, and monitoring for effectiveness and side effects." 11. Review of the provider's revised November 2024 Drugs: Review of Orders For Discontinuation policy revealed that "A procedure whereby the dosage and schedule of medications will be reviewed by physicians." "The timeframe for review of orders for continuation or discontinuation will apply to the following categories: Controlled Substances will be discontinued in 30 days, Antibiotics will be discontinued in 7 days, Anticoagulants will be discontinued in 30 days, Colchicine for acute gout attacks will be discontinued in 48 hours, Ketorolac (Toradol) will be discontinued in 5 days, and all other drugs not otherwise ordered for a specific time or number of doses will be discontinued in 60 days." "The medication needing review will not automatically discontinue and will remain active until discontinued by the physician." "The physician will have three options under this activity, that includes Review, which will reset the review date for the medication, Discontinue, which will discontinue the medication, and Modify, which will modify the medication order and reset the review date." Psychotropic medications were not included in the policy to include PRN (as needed) orders and their 14-day stop dates.			F0605			
F0657 SS = E	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			F0657	All current residents' care plans will be audited by the contracted MDS Company, with assistance from the Director of Nursing (DON) and Assistant Director of Nursing (ADON), to ensure care plans are comprehensive, pre-season-centered, and revised to reflect current resident needs, physician orders, and services provided. Any identified discrepancies.		7/9/2026

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F0657 SS = E	Continued from page 47 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 observation, interview, record review, and policy review, the provider failed to ensure the residents' care plans (personalized plan that addresses a resident's care needs, goals, and interventions) were reviewed and revised to reflect the current care needs for nine of thirteen sampled residents (3, 5, 6, 9, 14, 18, 21, 22 and 32). Findings include: 1. Observation on 5/26/26 at 1:22 p.m. in resident 18's room revealed a nebulizer machine on her bedside table, with a mask and tubing attached and stored on top of the machine. 2. Review of resident 18's electronic medical record (EMR) revealed she was admitted to the facility on 3/10/26. Her 3/10/26 Brief Interview of Mental Status (BIMS) assessment score was 05, which indicated her cognition was severely impaired. She had diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe (COPD),	F0657	including missing interventions or failure to update following a change in condition, will be promptly corrected. An audit of 100% of current residents will be completed to ensure care plans are developed within required time frames and revised timely with any significant change in condition, physician order, or service. Education has been provided to license nursing staff, the MDS Coordinator, DON, ADON, and designees on care plan requirements, including timing, development of person-centered interventions, and the need to update care plans with any change in condition. Care plans will be reviewed and updated: · Within required time frames (baseline care plans within 48 hours; comprehensive care plans within 7 days of completion of the MDS) · With any significant change in condition · Following physician order changes, incidents, or new diagnoses. The interdisciplinary team (IDT), including MDS, nursing, therapy, dietary, and social services, will participate in the development and revision of care plans to ensure a comprehensive and coordinated approach. All residents identified with behavioral health needs will have individualized, non-pharmacological interventions included in their care plans. The DON, ADON, MDS Coordinator, or designee will complete audits of care plans as follows: · Weekly audits of 5 residents for 4 weeks · Monthly audits for 3 months · Quarterly audits thereafter Audit results will be reviewed through the facility's QAPI program, and additional corrective actions will be implemented as needed to ensure ongoing compliance. The care plan policy has been updated and submitted to the contracted MDS Company for review. The off-site MDS Company was educated on 6/30/2026	

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F0657 SS = E	Continued from page 48 type 2 diabetes mellitus (a condition involving disruptions in how the body regulates blood sugar), chronic kidney disease (a condition involving the kidneys that are permanently damaged and can't properly filter waste and extra fluid from the blood), and weakness. Resident 18 had 3/10/26 physician orders for Budesonide inhalation suspension 0.5 milligram (mg)/2 milliliters (mL), two times a day, and Combivent Respimat inhalation aerosol solution 100 micrograms (mcg)/act ipratropium-Albuterol, before meals and at bedtime, both for her COPD. Resident 18's comprehensive care plan dated 3/23/26 did not document that she required the use of respiratory treatment and did not indicate her documented diagnosis of COPD. No interventions, measurable objectives, or monitoring related to her COPD, such as respiratory treatments, medications, and cleaning of her nebulizer equipment, were addressed in her care plan. 3. Observation on 5/26/26 at 3:26 p.m. resident 9 was yelling out that she needed to use the restroom. Contracted travel certified nursing assistants (CNA) U and CNA AA brought in a stand aide lift (a manual lift used to assist from a seated to a standing position), assisted resident 9 out of her bed, into the stand aide lift, and rolled the stand aide lift into the bathroom so resident 9 could use the bathroom. 4. Review of resident 9's EMR revealed she was admitted to the facility on 12/18/23. Her 2/27/26 Brief Interview of Mental Status (BIMS) assessment score was 3, which indicated her cognition was severely impaired. Her diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) with agitation, and a stroke (blood flow to the brain is interrupted) resulting in weakness or paralysis of the left side of her body. She had a 9/5/25 physician's order for lorazepam 2 milligrams per milliliter (mg/ml) (an anti-anxiety medication) to be administered 0.25 milliliters (ml) every two hours as needed for agitation or anxiety. The physician's order did not have an end date. Her 5/27/26 care plan did not indicate she had agitation or anxiety or identify any non-pharmacological interventions for agitation or anxiety. Her care plan did not indicate how she			F0657			

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F0657 SS = E	Continued from page 49 transferred out of bed, it did not indicate if she walked or used a wheelchair, and it did not indicate if she required assistance with dressing, bathing, or eating. 5. Observation on 5/26/26 at 3:30 p.m. of resident 32 in her room revealed she was seated in Broda chair (a specialized, ergonomic medical wheelchair or recliner) in a semi-reclined position. 6. Review of resident 32's EMR revealed she was admitted to the facility on 4/16/26. Her 4/22/26 BIMS assessment score was 14, which indicated her cognition was intact. Her diagnoses included dementia with agitation and a stroke resulting in weakness or paralysis affecting the left side of her body. She had been placed on frequent checks and was referred to psychiatry due to her expressions of suicidal thoughts. She had 4/24/26 occupational therapy evaluation completed by occupational therapist DD. It was recommended at that time resident 32 use a Broda chair for positioning. She had a 4/16/26 physician's order for mirtazapine 7.5 milligrams (mg) (an antidepressant medication) one tablet to be administered at bedtime for depression; a 4/17/26 physician's order for lorazepam 1 mg (an anti-anxiety medication) one tablet to be administered every eight hours as needed for anxiety; a 4/21/26 physician's order for lorazepam 1 mg one tablet to be administered two times per day; a 4/21/26 physician's order for olanzapine 10 mg (an antipsychotic medication) one table to be administered two times per day for dementia with agitation; and a 4/25/26 physician's order for quetiapine 50 mg (an antipsychotic medication) administer one tablet in the afternoon for agitation. Her 5/28/26 care plan had a focus area of "uses psychotropic medications r/t [related to] depression, anxiety, and behavioral management." There were no non-pharmacological interventions identified within that focus area. Her care plan indicated she had displayed "significant aggressive behaviors", and the intervention was to provide one to one care for her if she poses a risk to herself or others. Potential triggers for her aggressive behavior were not identified. Her history of suicidal thoughts was not identified on her care plan nor triggers or interventions for those thoughts. Resident 32's use of a Broda chair to optimize positioning was not	F0657		

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F0657 SS = E	Continued from page 50 identified on her care plan. 7. Observation and interview on 5/26/26 at 3:39 p.m. with resident 22 revealed she had a scoop mattress (a mattress designed with raised, contoured edges and a lower, scooped center) and bed rails/grab bars (bars attached to the bed) on both sides of her bed. She stated that she fell out of bed about a year ago. She could get in and out of bed without assistance, did not use the grab bars, and was unsure why the scoop mattress remained on her bed. 8. Review of resident 22's EMR revealed she was admitted on 4/22/24. Her 3/10/26 BIMS assessment score was 15, which indicated her cognition was intact. There was a 4/22/24 physician's order for a "Pressure Reducing Mattress: Check Q [each] Week to Ensure Proper Functioning and Placement on Bed at bedtime every Sun[day]." Her 3/11/26 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 that she was independent with bed mobility, transfers, and toileting. Her 3/30/26 care plan indicated she required "assistance by staff to turn and reposition in Bed...", that she used a "walker with one assist to go to and from activities" and that she required "assistance by staff for toileting." There was no documentation in resident 22's care plan that she required the use of a scoop mattress, the level of assistance that she required to complete bathing and dressing tasks, transfers, or mobility in her room. 9. Interview on 6/1/26 at 2:18 p.m. with DON B regarding resident 22's scoop mattress revealed that no assessment for resident 22's safe use of the scoop mattress had been completed, the use of the scoop mattress was not included in resident 22's care plan, and the provider did not have a policy for the use of the scoop mattress. She did not think a policy or an assessment for the use of a scoop mattress was needed. DON B stated that resident 22's use of a scoop mattress should have been included in the care plan. The scoop mattress was			F0657			

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F0657 SS = E	Continued from page 51 placed on resident 22's bed last year after she fell, at the request of a family member of resident 22. 10. Observation on 5/27/26 at 9:36 a.m. with resident 6 and resident 14 in their shared room revealed that resident 6 was seated upright in a Broda (a specialized, ergonomic medical wheelchair or recliner) chair. Resident 14 was seated in a Broda chair in a semi-reclined position. 11. Review of resident 6's EMR revealed he was admitted to the facility on 11/17/25. His 5/14/26 BIMS assessment score was 5, which indicated his cognition was severely impaired. He had an 11/13/25 physician's order for Sertraline HCl oral tablet 100 mg (an antidepressant medication used to treat mental health conditions like major depressive disorder), give 100 mg by mouth in the morning for depression, a 1/23/26 physician's order for Haldol 5 mg (an antipsychotic medication; a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions): "give 10 mg by mouth every 6 hours as needed for agitation," and a 2/20/26 physician's order for Seroquel 25 mg (an antipsychotic medication), one tablet by mouth two times a day for agitation. There was no documentation in resident 6's 5/20/26 care plan that he received antidepressant and antipsychotic medication. There was a focus area where he "had a behavior of inappropriate touching to [of] female staff." There were no behavior management or non-pharmacological interventions for those behaviors. There was no documentation that he had a mental health diagnosis or a severe behavioral disorder. There was no documentation in that care plan that he required the use of a Broda chair, nor the level of assistance that he required to complete bathing, dressing, transfers, and toileting tasks. 12. Review of resident 14's EMR revealed he was admitted to the facility on 2/11/26. His 5/14/26 BIMS assessment score was 13, which indicated his cognition was intact. There was no documentation in resident 14's 4/15/26 care plan that he required the use of a Broda chair, nor the level of assistance that he required to complete bathing, dressing, transfers, and toileting tasks. 13. Observation on 5/28/26 10:30 a.m. with resident	F0657		

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F0657 SS = E	Continued from page 52 5, certified nursing assistant (CNA) AA, and CNA EE revealed that resident 5 was transferred from her wheelchair to the bathroom with a stand aid lift (a mechanical lift used to assist from a seated to a standing position), and there were no side rails/grab bars (bars attached to the bed) on her bed. 14. Review of resident 5's EMR revealed she was admitted on 3/11/25. There was a 3/19/25 physician's order "side rails to promote independence and increase safety," and a physician's order "Ok to use Purwick catheter system [a non-invasive, external urine management system] due t[o] incontinence," which was discontinued on 12/12/25. Her 3/10/26 care plan indicated she was able to transfer with supervision, that she required the use of a full body lift with staff assistance for her safety," and that restorative therapy was working on resident 5's request to use a stand lift. Her care plan also indicated that she used side rails/grab bars on her bed for her safety, and she used a Purwick catheter system due to incontinence. Her 5/19/26 MDS assessment indicated her BIMS assessment score was 13, which indicated her cognition was intact, and that she was dependent with toileting tasks, and required substantial/maximal assistance with bathing and dressing. There was no documentation in resident 5's care plan that indicated the level of assistance she required to complete bathing, dressing tasks or toileting tasks. 15. Review of resident 21's EMR revealed he was admitted to the facility on 10/23/25. His 4/21/26 BIMS assessment score was 03, 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), dementia (a group of symptoms affecting memory, thinking, and social abilities) with agitation and behavioral disturbance, neurocognitive disorder with Lewy Bodies (a progressive brain disorder caused by abnormal protein clumps that damage nerve cells that affects thinking, memory, movement, sleep, and behavior), and obstructive sleep apnea (a disorder when your breathing repeatedly stops and starts during sleep because the throat muscles relax,			F0657			

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F0657 SS = E	Continued from page 53 causing the airway to collapse and block airflow). He had a 10/23/25 physician's order for donepezil 10 milligram (mg) one tablet by mouth in the morning for his dementia. Resident 21's care plan, dated 10/23/25, had an intervention with the incorrect dose for that medication. The intervention listed the medication as "Donepezil HCL 100 Mg PO BID." The dose on the care plan had an extra zero, indicating it was 100 mg instead of the physician's ordered 10 mg, and the care plan reflected that he should receive it twice daily rather than once daily. He had physicians' orders dated 10/24/25 for lorazepam Intensol oral concentrate 0.25 milliliters (mL) (an antianxiety medication) by mouth every two hours PRN (as needed) for agitation and for 0.5 mL by mouth every two hours PRN for agitation. Resident 21's care plan, dated 10/23/25, had an intervention with the incorrect dose for that medication. The intervention listed the medication as "Lorazepam 0.5 mg-1 mg Q [every] 2 HRS [hours] PRN." He had physicians' orders dated 3/6/26 for Risperdal 1mg (an antipsychotic medication that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions), give 1.5 mg (1.5 tablets) by mouth in the morning for agitation and 2 mg by mouth every 24 hours PRN, may give at bedtime for agitation or anxiety. Resident 21's care plan, dated 10/23/25, had an intervention with the incorrect dose for that medication. The intervention listed the medication as "Risperdal 2 Mg PO [by mouth] at HS [bedtime]." He had physicians' orders dated 4/2/26 for sertraline 100 mg (an antidepressant medication), 1 tablet by mouth in the morning and 50 mg (1/2 tablet) at bedtime for depression (a mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities). Resident 21's care plan, dated 10/23/25, had an intervention with the incorrect dose for that medication. The intervention listed the medication as "Sertraline 100 Mg BID [twice daily]." He did not have a diagnosis of depression. Resident 21's care plan dated 10/23/25 continued to include interventions and referral to hospice services, despite the resident's hospice services	F0657		

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F0657 SS = E	Continued from page 54 being discontinued on 1/16/26. The facility did not update the care plan to reflect resident 21's current status and needs, and did not address goals and interventions to include the risks associated with psychotropic medication use. Resident 21's 10/23/25 care plan was not individualized or person-centered related to his psychotropic medications. 16. Review of resident 3's EMR revealed she was admitted to the facility on 12/12/24. Her 5/15/26 BIMS assessment score was 11, which indicated her cognition was moderately impaired. Her diagnoses included anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and dementia with behavioral disturbance. She had a 7/29/25 physician's order for alprazolam 0.5 milligrams (mg) (an anti-anxiety medication), one tablet to be administered as needed for anxiety. The physician's order did not have an end date. She had a 12/23/25 physician's order for haloperidol 5 mg (an antipsychotic medication; a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions), one tablet to be administered as needed for agitation. The physician's order did not have an end date, and she needed to be seen by a physician to have this reordered on 1/6/26. She had a 12/23/25 physician's order for Seroquel 50 mg (an antipsychotic medication), one tablet to be administered at bedtime for behaviors. The behaviors that the Seroquel was ordered to treat were not identified. Her 5/28/26 care plan had a focus area stating she received psychotropic medication related to behavior management. That focus area did not identify what her behaviors were or non-pharmacological interventions for those behaviors. A focus area stated she had hallucinations and indicated she was taking olanzapine (an antipsychotic medication) for anxiety, agitation, and psychosis (a state of losing touch with reality). She did not have a physician's order for this medication. She did not have a diagnosis of psychosis or hallucinations, and there were no non-pharmacological interventions for these symptoms identified in her care plan. 17. Interview and EMR review on 5/28/26 at 9:17			F0657			

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F0657 SS = E	Continued from page 55 a.m. with registered nurse (RN) Q revealed she would expect the care needs of each resident to be in their care plan. The care plans should include the assistance the resident requires for transfers, dressing, eating, and toileting. The nurses charted resident behaviors on the residents' medication administration record (MAR) or treatment administration record (TAR). The certified nursing assistants (CNA)s would notify the nurse if a resident had displayed a behavior. She did not know how the CNAs would identify what behaviors the residents had or what the non-pharmacological intervention for that behavior was. She acknowledged some of the residents' behaviors and interventions were identified in their care plans, but others did not. 18. Interview on 6/1/26 at 11:38 a.m. with CNA S revealed that she knew the level of assistance that a resident needed to complete bathing, dressing, and transfers because that information was on the resident's care plan in the EMR. She expected a resident's care plan to contain information about a resident's behaviors and interventions or solutions to manage those behaviors. She indicated that a resident's care plan had all the information she needed to care for the residents, including their cognitive status, if the resident required special equipment for transfers and positioning. There was also a note on each residents bathroom door that indicated how a resident transferred. She thought that DON B or assistant DON C updated the care plan if there was a change in how she was to care for or transfer a resident. 19. Interview on 6/1/26 at 12:17 p.m. with DON B revealed that the facility used an external Minimum Data Set (MDS) company to complete resident care plans when 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) were completed. She stated that the company was responsible for updating the resident's care plan. She was unaware that the care plans for residents 3, 5, 6, 9, 14, 18, 21, 22, and 32 were neither person-centered nor up to date with those residents' individual needs. DON B said she would email the external MDS company if she became aware that something needed to be added to or updated on a resident's care plan. DON B and ADON C were responsible for updating resident care plans.			F0657			

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F0657 SS = E	Continued from page 56 DON B stated that the care plans should have contained information on the resident's physical ability or the level of assistance they require to complete bathing, dressing, toileting, and transfer tasks She expected the CNAs to use the residents' care plan to know what care each resident required. The CNA's daily assignment sheet also included information on the level of assistance and equipment needed to transfer a resident. She expected the residents' use of a Broda chair and side rails to be included in the care plan. She expected monitoring for the use of antidepressant and psychotropic medications, the resident's behaviors, and non-pharmacological approaches to be included in the resident care plan. 20. Review of the provider's revised February 2020 Care Plans: Preliminary, Comprehensive and Reviews policy revealed "An interdisciplinary team, in coordination with the resident and his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident." "Each discipline enters their portion of the comprehensive care plan into PointClickCare EMR [an electronic medical record] and works with the interdisciplinary team members to maintain a care plan for each resident. PointClickCare shall always have the most updated care plan for each resident." "Care plans are revised as changes in the resident's condition dictates and reviewed at least quarterly." " The Comprehensive Care Plan is designed to: Incorporate identified problem areas and risk factors... Enhance the optimal functioning of the resident." "CNA [certified nursing assistant] staff, Day/Night, shall be responsible for reviewing and revising their drop sheets to reflect care... Changes in the resident's condition must be reported to the RN [registered nurse] MDS [minimum data set] coordinator so that a review of the resident's assessment and care plan can be made. Daily care and documentation must be consistent with the resident's care plan." "The Care Planning Committee/Team is responsible for keeping care plans on a current status and for periodic review and updating of care plans..."			F0657			

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F0657 SS = E	Continued from page 57 21. Review of the provider's 1/12/26 Behavioral Health Management policy revealed, "Staff will proactively assess, monitor, and manage behavioral symptoms using individualized, nonpharmacological and clinically appropriate interventions while ensuring resident dignity, safety, and regulatory compliance." "Each resident with behavioral health needs must have: -An individualized care plan addressing behaviors -Identified triggers and early warning signs -Specific interventions and staff approaches" "Staff must prioritize non-drug approaches"	F0657		
F0700 SS = E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure physician's orders, in accordance with the	F0700	Resident #17: Bed was immediately removed and replaced with a bed equipped with appropriate, secure bedrails. Resident #21: Bedrails were removed as they were not clinically indicated. Residents #25 & #26: Bedrails were immediately tightened and secured to eliminate instability. Resident #25: A 5-inch gap between mattress and headboard was immediately corrected by placing a tightly rolled comforter/bolster (this is temporary) to eliminate the entrapment zone. Residents #6 & #14: Mattresses were secured using manufacturer-approved metal corner brackets on all four corners, eliminating gaps between mattress and rails Bedrails were removed in four resident rooms where they were not needed for mobility or positioning. The Administrator, Director of Nursing (DON), and Maintenance conducted immediate room-to-room audits of all beds.	7/9/2026

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NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST , WINNER, South Dakota, 57580			
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F0700 SS = E	Continued from page 58 provider's policy, were obtained before bed rails/grab bars (bars attached to the bed) were installed for two of ten sampled residents (6 and 26), alternatives to the bed rails/grab bars were attempted before the bed rails/grab bars were installed, the risks versus benefits of bed rails/grab bars were reviewed with the resident, or the resident's representative, entrapment zone assessments were completed, and a consent for the bed rails/grab bars were obtained for seven of ten (6, 14, 17, 21, 22, 25, and 26) who had bed rails/grab bars on their bed. Findings include: 1. Observation and interview on 5/26/26 at 3:39 p.m. with resident 22 revealed she had a scoop mattress (a mattress designed with raised, contoured edges and a lower, scooped center) and bed rails/grab bars (bars attached to the bed) on both sides of her bed. She stated that she fell out of bed about a year ago. She could get in and out of bed without assistance, did not use the grab bars, and was unsure why the scoop mattress remained on her bed. 2. Review of resident 22's electronic medical record (EMR) revealed she admitted on 4/22/24. Her 3/10/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. There was a 4/22/24 physician's order for a "Pressure Reducing Mattress: Check Q [each] Week to Ensure Proper Functioning and Placement on Bed at bedtime every Sun[day]," and a 4/23/24 physician's order for "Bilateral bed rails for repositioning and safety while in bed." There was no documentation to indicate when resident 22's side rail/grab bars or scoop mattress were installed on her bed. There was no documentation that alternatives were attempted before the recommendation or installation of the side rail/grab bars or scoop mattress, that the risks versus benefits of side rail/grab bars or scoop mattress were reviewed with the resident or the resident's representative, or a consent for the side rail/grab bars or scoop mattress was obtained before the installation of the side rail/grab bars or scoop mattress on resident 22's bed. There was no documentation that resident 22's safety for the use of the scoop mattress, or the risk for entrapment, had been assessed. The quarterly			F0700	All entrapment zones were assessed and measured, ensuring compliance with less than a 4.75 inches in total Immediate corrective actions included: --Installation of manufacturer-approved brackets --Temporary gap reduction (rolled comforters/bolsters) until permanent fixes completed --Ordering manufacture approved corner brackets --Brackets will be installed as soon as they arrive to the facility by maintenance, no later than October 1st, 2026 (this date had to be edited due to manufacturer has them on back order. A audit of all beds and mattresses in the facility was completed by: --Administrator --Director of Nursing --Maintenance staff All residents with: --Bedrails --Assistive devices --Specialty mattresses were evaluated for safety --Entrapment zones (Zones 1--7 where applicable) --Mattress fit and stability --Rail security Metal corner brackets required for mattress stabilization where applicable 4. MONITORING SYSTEM The facility will implement the following monitoring: --Weekly audits until brackets arrive --Monthly audits with no end date Audit includes: --Bedrail stability --Mattress fit and securement --Entrapment zone measurements --Date Side rails were added		

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F0700 SS = E	Continued from page 59 side rail/grab bar assessments completed did not assess for resident 22's risk of entrapment. 3. Interview on 6/1/26 at 2:18 p.m. with DON B regarding resident 22's scoop mattress and bed rails/grab bars revealed that no assessment for resident 22's safe use of the scoop mattress had been completed, the use of the scoop mattress was not included in resident 22's care plan, and the provider did not have a policy for the use of the scoop mattress. She did not think a policy or an assessment for the use of a scoop mattress was needed. Resident 22's use of a scoop mattress should have been included in the care plan. DON B thought that the scoop mattress and bed rails/grab bars were placed on resident 22's bed last year after she fell, at the request of a family member of resident 22. 4. Observation on 5/27/26 at 9:53 a.m., with resident 6 and resident 14 in their shared room revealed that both of their beds had right-side side rails/grab bars. The mattresses were not securely attached to the beds and created a gap between the side rail/grab bar and the mattress when the mattresses moved. The gap between resident 14's bed and the side rail/grab bar measured four and a half inches when the mattress slid to the wall when touched. 5. Review of resident 6's EMR revealed he was admitted to the facility on 11/17/25. His 5/14/26 BIMS assessment score was 5, which indicated his cognition was severely impaired. There was no documentation that a physician's order was obtained for the use of a side rail/grab bar on his bed, when the side rail/grab bar was installed on his bed, that alternatives were attempted before the recommendation or installation of the side rail/grab bar, that the risks versus benefits of side rail/grab bars were reviewed with the resident or the resident's representative, or that a consent for the use of the side rail/grab bar was obtained before the installation of the side rail/grab bar on resident 6's bed. Quarterly side rail assessment documentation started on 11/17/25. The 2/20/26 quarterly assessment was completed on 5/27/26, and the 5/12/26 quarterly assessment was completed on 5/28/26. The completed quarterly side rail/grab bar assessments did not assess for resident 6's risk of entrapment.	F0700	Side Rail Use Consent Form created and include the follow: --Reason for Side Rail --Alternatives/interventions attempted, Risk vs Benefit, signature of resident/representative, provider and nurse. --All residents with side rails signed the consent either in person or via phone. -- This will be done on all new residents within one week of admission. An audit will be done on all new residents. Taken to QAPI monthly, times two months, then quarterly times twelve months. This will be done by DON/ADON or designee.	

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F0700 SS = E	Continued from page 60 6. Review of resident 14's EMR revealed he was admitted to the facility on 2/11/26. His 5/14/26 BIMS assessment score was 13, which indicated his cognition was intact. He had a 2/24/26 physician's order "OK for side rails." There was no documentation of when the side rail/grab bar was installed on his bed, that alternatives were attempted before the recommendation or installation of the side rail/grab bar, that the risks versus benefits of side rail/grab bars were reviewed with the resident or the resident's representative, or that a consent for the use of the side rail/grab bar was obtained before the installation of the side rail/grab bar on resident 14's bed. The quarterly side rail/grab bar assessments completed did not assess for resident 14's risk of entrapment. 7. Observation on 5/27/26 at 9:53 a.m. with resident 17 revealed that she had a side rail on the left side of her bed, which was the side of the bed that was up against a wall in her room. The side rail loose and could be pulled away from the bed. It was not properly attached to the bed and was held in place with a zip tie. The side rail was not appropriate for use on that bed. The bar to which the side rail was attached was not attached to the frame of the bed, was loose and unsecured under the mattress, and could move around. 8. Review of resident 17's EMR revealed she was admitted to the facility on 3/14/15. Her Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her diagnoses included contracture, cerebral palsy, weakness, and dependence on a wheelchair. There was an 8/7/19 physician's order for "side rails for positioning", and a 3/5/24 physician's order for "left-side quarter bed rail for repositioning and safety." Resident 17 had an Alarm/Side Rail/Restraint Consent for Use dated 9/9/22 on file; it was signed by a former DON, but the consent was not signed by resident 17. A Side Rail Use Assessment was completed on 3/16/19, but it was not signed by resident 17. Quarterly side rail assessments were completed on 10/6/25, 1/20/26, and 4/1/26. No other quarterly assessments were provided prior to the 10/6/25 side			F0700			

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F0700 SS = E	Continued from page 61 rail assessment. There was no documentation to indicate when resident 17's side rail was installed on her bed. There was no documentation that alternatives were attempted before the recommendation or installation of the side rail, that the risks versus benefits of the side rail were reviewed with the resident or the resident's representative, as the consent dated 9/9/22 was not signed by resident 17 to indicate she received the information prior to the installation of the side rail on resident 17's bed. There was no documentation that resident 17's safety for the use of the siderail or the risk for entrapment had been assessed. The quarterly side rail assessments completed did not assess for resident 17's risk of entrapment. 9. Observation on 5/27/26 at 9:54 a.m., with resident 26 in his room, revealed he had side rails/grab bars on both sides of his bed. The right-side side rail/grab bar was loose and moved approximately four inches away from the mattress when touched. 10. Review of resident 26's EMR revealed he admitted to the facility on 12/1/20. His BIMS assessment score was 1, which indicated his cognition was severely impaired. There was no documentation that a physician's order was obtained for the use of a side rail/grab bars on his bed, when the side rail/grab bars were installed on his bed, that alternatives were attempted before the recommendation or installation of the side rail/grab bar, that the risks versus benefits of side rail/grab bars were reviewed with the resident or the resident's representative, or that a consent for the use of the side rail/grab bars was obtained before the installation of the side rail/grab bars on resident 26's bed. Quarterly side rail assessment documentation started on 6/9/21. The 12/3/25 and 3/25/26 quarterly assessments were completed on 5/27/26. The quarterly side rail/grab bar assessments completed did not assess for resident 26's risk of entrapment. 11. Observation and interview on 5/27/26 at 9:58 a.m. with resident 25 in his room revealed he had bilateral side rails on his bed. The right-side rail was loose and pulled away from the bed. Resident 25 was lying in bed with his head resting against the left side rail. He stated he did not use the side rails for transferring in or out of bed or repositioning while he was in bed.	F0700		

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F0700 SS = E	Continued from page 62 12. Review of resident 25's EMR revealed he was admitted to the facility on 1/9/24. He had a BIMS assessment score of 15, which indicated his cognition was intact. His diagnoses included alcohol induced dementia (a group of symptoms affecting memory, thinking, and social abilities caused by excessive prolonged use of alcohol), and an eye movement disorder. His 5/28/26 care plan indicated resident 25 was unable to see out of his left eye. Resident 25's 1/9/24 side rail and safety screen indicated bilateral side rails were recommended to be installed by occupational therapy due to: "[Resident 25 was using bed rails in [the] hospital. Without them he requires increased assistance. Recommending Bilateral rails." The physician signed the recommendation for bilateral side rails on 1/25/24. This assessment did not document if there were alternatives attempted prior to the recommendation or installation of the side rails. There was a 3/6/24 physician's order for the use of bilateral side rails to optimize independence and safety. There was no documentation to indicate when resident 25's side rails were installed on his bed. There was no documentation that the risks versus benefits of side rails were reviewed with the resident or the resident's representative and a consent for the side rails was obtained prior to the installation of the side rails on resident 25's bed. Quarterly side rail assessment documentation started on 1/10/25, one year after the bilateral side rails were recommended and continued until 9/8/25. There were no quarterly assessments completed in December 2025 or March 2026. The quarterly assessments did not assess for resident 25's entrapment risk. 13. Observation on 5/27/26 at 12:05 p.m. with resident 21 out of his bed, revealed that he had a half-rail on the right side of his bed, and the left side of his bed was up against the wall. The half-rail on the bed was loose. The gap between the loose right half-rail and his mattress measured five inches when the mattress was pushed to the wall, and the loose rail was pulled out from the bed. There was a 4.5-inch gap between his headboard and the head of the mattress when the mattress was pushed to the foot of the bed.	F0700		

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F0700 SS = E	Continued from page 63 14. Review of resident 21's EMR revealed he was admitted to the facility on 10/23/25. His 4/21/26 BIMS assessment score was 03, 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), dementia (a group of symptoms affecting memory, thinking, and social abilities) with agitation and behavioral disturbance, and neurocognitive disorder with Lewy Bodies (a progressive brain disorder caused by abnormal protein clumps that damage nerve cells that affects thinking, memory, movement, sleep, and behavior), and obstructive sleep apnea (a disorder when your breathing repeatedly stops and starts during sleep because the throat muscles relax, causing the airway to collapse and block airflow). There was a 12/22/25 physician's order for "Siderails and fall mat for safety and to promote independence." Quarterly side rail assessments were completed on 10/31/25 and 4/20/26. No quarterly side rail assessment was completed in January 2026, and no other quarterly side rail assessments were provided prior to the 10/31/25 side rail assessment. There was no documentation indicating that consent to install the side rail for resident 21 was obtained. There was no documentation to indicate when resident 21's side rail was installed on his bed. There was no documentation that alternatives were attempted before the recommendation or installation of the side rail, that the risks versus benefits of the side rail were reviewed with the resident or the resident's representative. There was no documentation that resident 21's safety for the use of the siderail or the risk for entrapment had been assessed. The quarterly side rail assessments completed did not assess for resident 21's risk of entrapment. 15. Interview on 5/28/26 at 10:05 a.m., with DON B revealed she was unaware that the side rail/grab bars and mattresses needed to be assessed for entrapment risks. She was unsure if maintenance assessed the rails or mattresses for entrapment risk in any "zones". She stated that when a resident or their representative requested a side rail/grab bar, the therapy department would assess the resident using a checklist, which did not contain resident risk for entrapment, interventions tried, or obtain resident consent for the use of the side rail/grab bar. She thought that if a resident wanted a side rail/grab bar, they could request one, and one would be provided. She expected the nurse assigned to the	F0700		

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

FORM APPROVED

OMB NO. 0938-0391

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F0700 SS = E	Continued from page 64 resident that day to obtain a physician's order and complete a quarterly assessment when it was due to be completed. 16. Interview on 6/1/26 at 11:56 a.m. with DON B revealed there was no documentation available related to when the side rails were installed on residents' beds. 17. Review of the provider's undated Bed Safety and Entrapment Prevention Policy revealed: The policy did not indicate when it was developed, reviewed, or approved. The purpose was "To ensure a safe sleeping environment by preventing bed-related accidents, including entrapment, falls, and injury related to bedrails, mattresses, and bed systems." "The facility is committed to maintaining all beds, mattresses, and assistive devices in a safe condition. Bed systems will be assessed, maintained, and used in a manner that minimizes the risk of entrapment and injury, in accordance with CMS F689 requirements and FDA bed safety guidance. Bedrails will not be used as restraints and will only be utilized when clinically indicated and safe." "All beds must: Be in good working condition, Have securely attached side rails or assistive devices (if used), Have a properly fitted mattress, Be compatible with all components (no mixing of incompatible parts), Be free of excessive gaps." "All gaps must measure ≤ 4.75 inches where applicable." "Special attention is given to: Space between mattress and rail, Mattress and headboard/footboard, Split rails and joints." "Bedrails will: Only be used when clinically necessary. Require: Assessment prior to use, Care plan documentation, Be removed when: Not used for mobility or positioning, Risk outweighs benefit." "Mattresses must: Fit securely within the bed frame, Not slide, shift, or leave gaps, Be secured using: Manufacturer-approved systems (e.g., corner brackets or stops), Be replaced if worn or incompatible." "Initial and Routine Assessments The following will be completed: On admission, With change in			F0700			

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F0700 SS = E	Continued from page 65 condition, Quarterly and annually, After any bed or mattress change. Assessment includes: Bedrail necessity, Mattress fit and stability, Entrapment zone measurement." "Staff Responsibilities: All Staff: Assess need for bedrails, Monitor for signs of entrapment risk, Report hazards immediately. Maintenance: Ensure all beds are properly assembled, Perform repairs and installations, Maintain approved equipment only, Monthly audits on all beds. Administration: Ensure policy compliance, Monitor through QAPI process." 18. Review of the provider's revised 1/6/25 Side Rail policy revealed "Quarter rails and bed canes that are approved for the beds can be used that are affixed to the bed and evaluated for safety and functioning by maintenance... A side rail assessment will be completed by therapy and/or nursing when there is a desire expressed by the resident or [a] need [is] reported by the nursing staff. Physicians[] orders will be obtained prior to placing the side rail on the bed. A side rail assessment form will be completed quarterly and prn [as needed] by the MDS [minimum data set] coordinator or designee... and prn for use or desired change. Resident and/or family education is provided with new orders received from [the] physician for side rail use...Maintenance will be notified with side rail evaluations and prn for an inspection of the side rail, how it fits the bed, tightness, and to evaluate the mattress for wear and distance from the rail. Continued use of the side rail will be reviewed with the family quarterly and prn [with] changes in condition. The Director of Nurses or designee will be contacted when there is a determination that a side rail order is being requested."	F0700		
F0712 SS = E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	F0712	--Resident 6 was seen on 5/13/26 and schedule for rounds on 7/7/2026 --Resident 3 will be seen on physician rounds on 6/29/26 --Resident 9 was seen on 6/9/2026 A 100% chart audit will be completed by 7/9/2026 to ensure all residents are in compliance with the policy the audit will contain the following: ---Name ---Admit date ---Last visit ---Next visit ---Visit completed on time (y/n) ---Days late	7/9/2026

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F0712 SS = E	Continued from page 66 §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and admission packet review, the provider failed to ensure that residents were seen by a physician at least once every 30 days for the first 90 days after admission for two of four sampled residents (3 and 6), and at least once every 60 days thereafter for one of four sampled residents (9). Findings include: 1. Review of resident 9's electronic medical record (EMR) revealed she was admitted to the facility on 12/18/23. Resident 9's January 2025 through May 2026 physician's visit documentation revealed she was seen by medical director L on 1/14/25 and then not seen by a physician in the facility until 4/18/25. There were 94 days between the two physician's visits. After the 4/18/25 physician's visit she did not have a physician's visit until 8/14/25. There were 118 days between the two physician's visits. On 10/16/25 resident 9 was seen by medical director L, there were no signed physician's orders for that visit. She had physician's visit with medical director L on 12/12/25 and then did not have another physician's visit until 4/21/26. There were 130 days between those two physician's visits. 2. Review of resident 3's EMR revealed she was admitted to the facility on 12/12/24. Resident 3's January 2025 through May 2026 physician's visit documentation revealed she was not seen by a physician until 3/18/25, 96 days after she was admitted to the facility. 3. Review of resident 6's EMR revealed he was admitted to the facility on 11/17/25. Review of	F0712	Policy for physician rounds has been completed. Physician/providers were educated on 6/30/2026. Audit will be presented to QAPI by DON/ADON or designee. - Weekly audits x 4 weeks on all residents due for rounds - Monthly audits x 3 months for all residents due for rounds - Quarterly audits x 2 quarters for all residents due for rounds. Audits will include: - Name - Admit date - Last visit - Next visit - Visited completed - Days late		

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NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST , WINNER, South Dakota, 57580	
(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
F0712 SS = E	Continued from page 67 resident 6's November 2025 through May 2026 physician's visit documentation revealed he was seen by medical director L on 12/12/25, 1/22/25, 3/24/25, and 5/13/26. There were 61 days between his 1/22/25 and 3/24/25 physician visits. 4. Interview on 6/2/26 at 10:01 a.m. with medical director L revealed his physician rounds schedule was organized by director of nursing (DON) B and assistant DON C and he saw the residents according to the schedule that DON B and assistant DON C made for him. Each physician visit he completed he signed a physician's order and completed a progress note for that resident's visit. He was aware that a newly admitted resident needed to be seen by a physician every 30 days for the first 90 days and then every 60 days after that. 5. Interview and EMR review on 6/2/26 at 11:12 a.m. with DON B resident 9 was not seen in March 2025 because she had been in the hospital from 3/1/25 through 3/4/25. March physician's rounds were on 3/11/25, and she thought the hospitalization replaced resident 9's physician visit. She verified that resident 9 had not been seen by a physician from April 2025 through August 2025, in December 2025, or April 2026. She acknowledged that the time between those physician's visits did not meet the required every 60-day physician visits. There was no documentation to support resident 3 was seen after she was admitted to the facility on 12/12/24 until she was seen on 3/18/25. She acknowledged resident 3 was not seen every 30 days for the first 90 days after her admission to the facility to meet the required physician visits. 6. A policy related to physician visits was requested on 6/2/26 at 9:20 a.m. from DON B and was not received by the end of the survey. 7. Review of the provider's undated Admission Packet revealed, Physician Services "During the first ninety (90) days after the resident's admission to the facility, a physician must see the resident at least every thirty (30) days. After that, a physician will see the resident at least once every sixty (60) days."	F0712		

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F0755 SS = E	Pharmacy Svcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure proper medication storage practices for one of one resident medication refrigerators in one of one medication storage room. Specifically, expired medications and supplies were not discarded as required; temperatures in the resident medication refrigerator were not consistently monitored and documented; and unlabeled resident beverages were stored in the resident medication refrigerator with resident medications. Findings include:	F0755	- Any medications identified during the survey as improperly labeled or stored were immediately corrected. - Medications without proper labeling (including resident name, drug name, strength, expiration date, or beyond-use date) were removed and either relabeled appropriately or disposed of per facility policy. - Medications found to be stored improperly (e.g., incorrect temperature, unsecured areas) were immediately relocated to appropriate storage areas. - Refrigerated medications were reviewed, and temperatures were verified to be within acceptable ranges. Any discrepancies were addressed immediately. - A 100% audit of all medication storage areas was conducted, including: - Medication rooms - Refrigerators - Treatment carts and storage areas - The audit included: - Proper labeling of all medications - Expiration date checks - Appropriate storage conditions (temperature, light, security) - Any identified concerns were corrected immediately. - All expired items in the medication room were discarded - The facility reviewed and updated the medication storage and security policy to ensure compliance with regulatory standards. - Education will be provided to all licensed nurses and applicable staff at a mandatory meeting and will be completed by July 9, 2026. Any staff unable to attend will receive education prior to their next scheduled shift. - A process has been implemented to ensure medications are destroyed within one week of being discontinued or identified for disposal. All medications that were awaiting destruction were properly destroyed on May 29, 2026, and this new process will be followed moving forward. - Temperature logs for the medication refrigerator were initiated on June 4, 2026, and will be maintained daily to ensure proper storage conditions.	7/9/2026

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F0755 SS = E	Continued from page 69 1. Observation and interview on 5/27/26 at 3:31 p.m. of the medication storage room with contracted travel registered nurse (RN) V revealed that the door was locked and that she used a key to enter. She stated that she held the key to the medication storage room for her shift and that every nurse had access to the medication room key during their shifts at the facility. The resident's medication refrigerator contained the resident's personal beverages and their medications stored together. Resident 5's Trulicity 3mg/0.5ml syringe box was wet, as two boxes of opened, unlabeled wine boxes were stored above the medications. One box of wine was leaking from the spicket. Contracted travel RN V acknowledged that the cardboard medication container for resident 5's medication was wet. There was an unlabeled 12-pack of beer stored in the refrigerator as well. Additionally, a clear plastic bag containing three boxes of influenza vaccine Adjuvanted on the bottom shelf was wet. The following expired medications and supplies were stored on shelves in the medication storage room: • Eight boxes of COVID-19 Antigen Rapid Tests (5-test kits), expired 9/2/25 • One box (50 per box) Bionix lighted ear cures, expired 11/7/25 • Twenty-four boxes of COVID-19 Antigen Rapid Tests (2-test kits), expired 11/11/25 • Nine PureWick female external catheters, expired 4/28/26 • Five syringes of Influenza vaccine adjuvanted lot #407253, expired 5/6/26 • Eight syringes of Influenza vaccine adjuvanted lot #407257, expired 5/13/26 Contracted travel RN V acknowledged that the medications and supplies had expired and should have been removed from the medication storage room during the last monthly check. She acknowledged that residents' personal food and drinks should not be stored in the medication refrigerator due to the risk of contamination. She acknowledged that resident 5's medication container was compromised from the leaking wine spicket.	F0755	• All resident wine and alcoholic beverages were removed from the medication refrigerator to ensure appropriate and compliant use of medication storage areas. • The Director of Nursing (DON) and/or Assistant Director of Nursing (ADON) will complete weekly audits for four (4) weeks, then monthly for three (3) months to ensure ongoing compliance. Any identified concerns will be addressed immediately with re-education and corrective action as indicated. Findings will be reviewed through the QAPI process. Systematic Changes to Prevent Recurrence: The facility has implemented the following measures: • Implemented a Controlled Substance Diversion Prevention Policy • Established procedure to restrict access to unused, expired, and discontinued controlled substances • Enhanced medication storage security of unused, expired, and discontinued controlled substances, including logging and storage of controlled substances needing destruction in a tamper-evident container • Implemented controlled medications held for destruction shift checklist Staff Education 1. All licensed nurses, medication aides, and applicable staff will receive education on the Controlled Substance Diversion Prevention Policy. Part of bundle for all new staff and yearly. Monitoring and Quality Assurance 1. The Director of Nursing, Assistant Director of Nursing, or designee will conduct: - Weekly audits of controlled substance held for destruction records - Biweekly audits for the following 2 months - Monthly audits thereafter for an additional 3 months 2. Audit results will be reviewed at the facility's Quality Assurance and Performance Improvement Committee meetings	

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F0755 SS = E	Continued from page 70 Contracted travel RN V stated that controlled medications waiting to be destroyed were stored in the locked cupboard in the medication storage room. She was unsure of the medication destruction process. 2. Observation and interview on 5/27/26 at 4:14 p.m. with assistant director of nursing (ADON) C in the medication storage room revealed that outdated medications and supplies in the medication storage room were checked by night shift nurses the last day of the month, and nurses were expected to complete a fax request to the pharmacy to notify them that medications and supplies had expired and needed to be replaced. The resident medication refrigerator temperatures were to be monitored by the nurses every shift. She acknowledged that resident 5's cardboard medication container was wet from a leaking wine box stored above the medications. She was unsure if the resident's personal food and drinks could be stored in the medication refrigerator. ADON C acknowledged that two boxes of wine and a 12-pack of beer were not labeled with the resident's name or the date the wine boxes were opened. 3. Observation and interview on 5/27/26 at 4:19 p.m. with director of nursing (DON) B, in the medication storage room, revealed that temperatures should be monitored once or twice a day, but she was unsure. She acknowledged that no temperature log was maintained for May 2026. Temperature logs for February, March, and April 2026 were reviewed and revealed numerous missing temperature readings. She stated that the controlled medications were locked in a 2-door cupboard and that she, ADON C, and the scheduled working nurses had access to the key. DON B said that controlled medications were destroyed together by ADON C and licensed pharmacist M every one to two weeks. She said the controlled medications awaiting destruction were not counted each shift. 4. Review of the provider's resident medication refrigerator temperature log revealed that "The temperature of patient medication refrigerators is to be monitored and documented daily." "Store the medications under proper conditions as soon as possible and contact the pharmacy to determine if the potency of any of the medications has been affected, and recommendations for use or disposal." "If pharmacy recommends, dispose of open multiple-use vials of medication." "Defrost			F0755	3. Any identified concerns will result in immediate corrective action additional staff education, and follow-up monitoring. 4. Compliance trends and audit findings will be tracked and documented to ensure sustained improvement. All corrective actions will be completed by July 9, 2026		

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F0755 SS = E	Continued from page 71 immediately if needed." "Notify maintenance for recommendation regarding repair/maintenance/replacement." "Document the actions taken in the space provided on the back of this sheet." The February 2026 temperature log had missing temperature documentation on days 2, 6-7, 11-15, 18, 20-21, and 24-27. The March 2026 temperature log had missing temperature documentation on days 4-7, 14, 18-21, and 26-28. The April 2026 temperature log was missing temperature documentation every day except days 5 and 6. 5. Interview on 5/28/26 at 8:40 a.m. with RN Q revealed she was concerned about the number of controlled medications awaiting destruction. She reported there were numerous controlled medications in the locked cupboard in the medication storage room awaiting destruction with licensed pharmacist M and ADON C. RN Q stated that the controlled medications had been in the cupboard for several weeks, waiting to be destroyed. 6. Observation and interview on 5/28/26 at 11:46 a.m. with ADON C in the medication storage room, and the controlled medications revealed that the controlled medications were locked in a cupboard in the medication storage room. Numerous controlled medications were stored in the cupboard, and the cupboard was disorganized and did not have a clear system of order. The controlled medication disposition forms were not stored with the medications, requiring ADON C to search through the cupboard to match each medication with its corresponding form. She stated that the controlled medications were to be counted and then destroyed at least every one to two weeks. ADON C stated that she and licensed pharmacist M were usually the ones who counted and destroyed the controlled medications together, and that they had not done so in over 2 weeks. She acknowledged that controlled medications awaiting destruction were not counted daily for their accountability, and multiple staff nurses having access to them was a potential risk for diversion.	F0755		

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F0755 SS = E	Continued from page 72 She stated that all medications were destroyed in the RX Destroyer (a liquid, ready-to-use chemical drug destruction product that begins deactivating drugs upon contact with it). Review of destruction logs revealed that she and licensed pharmacist M last counted together on 3/14/26. She acknowledged that the controlled medications had not been destroyed by her and licensed pharmacist M for over two months. The cupboard contained the following unreconciled controlled medications awaiting destruction for residents 7, 8, 11, 13, 32, and 100: Resident 7: • Eight tablets of lorazepam 0.5 mg • Six tablets of lorazepam 0.5 mg • Six tablets of lorazepam 0.5 mg PRN • 29 mL of lorazepam Intensol 2 mg/mL • Two tablets of diazepam 10 mg • 25 mL of morphine sulfate oral solution 20 mg/mL Resident 8: • 21 mL of lorazepam Intensol oral concentrate 2 mg/mL • 75 tablets of hydromorphone 2 mg • 26 mL of morphine sulfate 100 mg/5 mL • 15 tablets of morphine sulfate ER 60 mg • 15 tablets of morphine sulfate ER 60 mg Resident 11: • One tablet of buprenorphine 2 mg Resident 13: • 15 tablets of hydrocodone/APAP 5–325 mg • 26 tablets of tramadol 50 mg • 22.5 mL of morphine sulfate 20 mg/mL • Nine fentanyl 25 mcg/hr patches			F0755			

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F0755 SS = E	Continued from page 73 Resident 32: • Three tablets of haloperidol 5 mg • One tablet of lorazepam 1 mg Resident 100: • 28.5 mL of morphine sulfate oral solution 20 mg/mL • Five fentanyl 25 mcg/hr patches • 29.25 mL of lorazepam Intensol oral concentrate 2 mg/mL Unknown • Two unidentified light-orange pills, stored in an unlabeled clear plastic medication cup 7. Interview on 5/28/26 at 12:28 p.m. with ADON C revealed that DON B reported to her that DON B found medications on the floor in former resident 8's room, but she was unsure of the exact date. She stated that DON B said the medication was brought to resident 8 by a family member or friend. ADON C acknowledged that the medication was not documented on a controlled log sheet, was stored without identification, and that she had no record of it being stored in the medication room cupboard. 8. Interview on 5/28/26 at 1:45 p.m. with DON B in the medication storage room revealed that she acknowledged that resident 5's cardboard medication container was wet and that two boxes of unlabeled, opened wine above were likely what had leaked onto the medication. She removed both open boxes of wine, placed them in the sink, and stated she would discard them. She removed a 12-pack of beer from the door of the medication refrigerator that was not labeled with a resident's name. She acknowledged that residents' personal food and beverages should not be stored in the medication refrigerator but should be placed in the hospitality refrigerator behind the nurses' station. She expected nursing staff to complete a thorough check of the medication storage room for expired medications and supplies monthly and dispose of them. She acknowledged that controlled medications awaiting destruction were not counted each shift for accountability, that every nurse who worked a shift	F0755		

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F0755 SS = E	Continued from page 74 had access to the keys for both the medication storage room and the cupboard. She agreed that the controlled medications had not been destroyed by ADON C and licensed pharmacist M for over two months. Additionally, she said that maintenance had access to the medication storage room and acknowledged there was potential for drug diversion. 9. Interview on 6/1/26 at 2:32 p.m. with licensed pharmacist M revealed she had been with the facility for one year and completed resident chart reviews, managed daily medication refills, and destroyed controlled medications with ADON C. She said that three months ago, she and ADON C changed to routinely destroying medications every other Tuesday to limit the number of controlled medications stored for destruction. Prior to that change, it was the facility contacting the pharmacy to come and destroy the controlled medications when needed. She said that RX Destroyer was used for the destruction of the controlled medications. Licensed pharmacist M was unsure whether another RN could destroy medications with her if ADON C was not available, and said she would have to ask DON B. She stated that she was at the facility frequently but did not have keys or access to the medication room or the locked cupboard that stored the controlled medications awaiting destruction. She was unsure if the controlled medications awaiting destruction were reconciled every shift until destroyed. She stated that there was concern for potential diversion when numerous people had access to keys. Licensed pharmacist M said that it was the nurses' responsibility to go through the medication room and carts for expired meds and supplies, and acknowledged that resident food and beverages should not be stored in the medication refrigerator. She acknowledged that waiting over 2 months to destroy controlled medications was not good practice and was a concern for potential drug diversion as well. She stated that she had not been involved in the facility's pharmacy policymaking. 10. Interview on 6/2/26 at 11:48 a.m. with DON B revealed that the unidentified medication that was stored in the locked cupboard in the medication room belonged to former resident 8 and was Dilaudid 2mg (an opioid medication used to treat moderate to severe pain) tablets that were brought in from home by his family or a friend. She acknowledged that the medication was not documented on a controlled log sheet, was stored in			F0755			

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F0755 SS = E	Continued from page 75 the cupboard unidentified, and she had no record of it being in the medication room cupboard. DON B didn't think about the medication being counted and destroyed because it was not a medication from the facility. She did not remember whether she documented the medication information in resident 8's EMR. 11. Interview on 6/2/26 at 12:31 p.m. with chief executive officer (CEO) A revealed that he expected nursing to go through the medication room monthly to check for expired medications and supplies and dispose of them. He stated that the controlled medications should be counted and then destroyed by licensed pharmacist M and ADON C when necessary. He was not aware that the controlled medications were not destroyed on a routine basis. He was not aware that the controlled medications had not been destroyed for over two months. He acknowledged that nursing staff have access to the keys to the medication storage room and the locked cupboard containing controlled medications awaiting destruction. He also confirmed that maintenance has a key and access to the medication storage room. 12. Medication storage, resident medication refrigerator, drug diversion, consultant pharmacist, and pharmacy services policies were requested between 5/27/26 and 6/2/26 during the survey; the facility did not have those policies for review. 13. Review of the provider's revised August 2018 Outdated Drug Control policy revealed that "Outdated medications will not be dispensed for patient use or allowed to remain in the dispensing area of the pharmacy or in patient areas." "Pharmacy personnel will check medications for dated items and remove all outdated packages from the shelves monthly." "Nursing stations and medication stock areas will be checked monthly for outdated items and replaced." "All outdated inventory will be removed and replaced by the pharmacy." 14. Review of the provider's reviewed September 2018 Drug Disposition and Destruction policy defined the "Procedure for proper disposition of medicines, which are discontinued because of the discharge or death of a resident; the drug is outdated; a drug is found that is not identifiable to a resident; the prescription is discontinued or changed; or destruction of a partial dose is required."	F0755		

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F0755 SS = E	Continued from page 76 "Schedule II, III and IV drugs [controlled medications] (medications with risk for abuse and addiction) will be destroyed by a pharmacist and a registered nurse (RN)." "Discontinued medications (excluding Schedule II, III, and IV drugs) may be kept up to one month after the discontinued date." "Destroy medications immediately if: resident was discharged or has expired." "Discontinued Schedule II, III, and IV drugs will be secured, and then destroyed as soon as the pharmacist is available." "Drugs with the exception of morphine oral solution and fentanyl patches, will be crushed and mixed in kitty litter in med room by the pharmacist and an RN and discarded." "Morphine oral solution and fentanyl will be flushed down the toilet." "Unless otherwise instructed, flush tablets, capsules, liquids, and contents of vials and ampules down the toilet." "If a drug is found that cannot be readily identified to a resident, the drug will be taken to a pharmacist for identification." "If the drug cannot be traced to a resident, it will be destroyed." "An attempt will be made to identify the resident and why the drug was not properly administered." "A documentation note will be written in the resident's medical record (Medication Reconciliation Form) by the person responsible for destroying the medications." "The note will be signed by those persons destroying the medications." "The drug disposition record must contain, as a minimum, the following information: date destroyed, name of the drug, dosage of drug, prescription number (if any), the quantity destroyed, method of destruction, and signatures of witnesses." "Completed drug disposition records must be forwarded to medical records for the resident's medical record." 15. Review of the provider's undated Admission Packet revealed that with food and beverages, "Family and friends may bring in food and non-alcoholic beverages as approved by the physician's ordered diet. Please report any food and beverages brought in. Alcoholic beverages are permitted only with a doctor's order and are kept in the medication room. Refrigerator space is available for small food and drink items in the facility nourishment room."	F0755			
F0756 SS = E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F0756			

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NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST , WINNER, South Dakota, 57580	
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F0756 SS = E	Continued from page 77 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to have a system in place to identify medication irregularities, report those irregularities to the physician, and for the physician to address the identified irregularities for four of four sampled residents (3, 6, 21, and 32) on psychotropic medications (drugs that affect brain activities associated with mental processes and behavior).	F0756	Plan of Correction F756-§483.54(c) Drug Regimen Review The consultant pharmacist completed a comprehensive review of each resident's medication regimen. Any identified medication irregularities were communicated in writing to the attending physician and Director of Nursing. Physician recommendations were reviewed, appropriate orders were obtained, and the medical record was updated to reflect actions taken. The Director of Nursing, Consultant Pharmacist, and/or designee completed a 100% audit of all current residents to verify: Monthly Drug Regimen Reviews were completed timely by the licensed pharmacist and included the following: Review of all antipsychotic/psychotropic medication orders Identification of PRN antipsychotic/psychotropic medication orders used beyond 14 days with recommendation for discontinuation Identification of potential duplication in antipsychotic/psychotropic medications with recommendation to evaluate for possible discontinuation and/or Gradual Dose Reduction Identification of medications with no supporting diagnosis in Point Click Care Identification of unused PRN medications All pharmacist recommendations were documented in writing and communicated to the attending physician and Director of Nursing. All identified deficiencies will be corrected by July 9, 2026.	07/09/26

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F0756 SS = E	Continued from page 78 Findings include: 1. Review of resident 3's electronic medical record (EMR) revealed she was admitted to the facility on 12/12/24. Her 5/15/26 Brief Interview of Mental Status (BIMS) assessment score was 11, which indicated her cognition was moderately impaired. Her diagnoses included anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and dementia (a group of symptoms affecting memory, thinking, and social abilities) with behavioral disturbance. She had a 12/23/25 physician's order for haloperidol 5 milligrams (mg) (an antipsychotic medication; a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions), one tablet to be administered as needed for agitation. The physician's order did not have an end date, and she needed to be seen by a physician to have this reordered on 1/6/26. She had a 12/23/25 physician's order for Seroquel 50 mg (an antipsychotic medication) one tablet to be administered at bedtime for behaviors. The behaviors the Seroquel was ordered to treat were not identified. 2. Review of resident 3's 1/1/25 through 5/1/26 monthly medication reviews and gradual dose reduction (GDR; systematic dose reduction over time to determine if the condition could be managed with a lower dose or discontinuation of the medication) recommendations revealed there were no recommendations made by the pharmacist to resident 3's physician regarding resident 3's haloperidol physician's order did not have an end date on the order or that the physician's order for Seroquel did not have a diagnosis or an identified behavior for which it was prescribed to treat. 3. Review of resident 32's EMR revealed she was admitted to the facility on 4/16/26. Her 4/22/26 BIMS assessment score was 14, which indicated her cognition was intact. Her diagnoses included dementia with agitation. She had a 4/16/26 physician's order for mirtazapine 7.5 mg (an antidepressant medication) one tablet to be administered at bedtime for depression. Resident 32 did not have a diagnosis of depression.	F0756	Systematic Changes The facility has revised its Drug Regimen Review process to include: 1. Tracking log maintained by the DON/designee to monitor PRN antipsychotic/psychotropic medication orders 2. Tracking log maintained by the DON/designee to monitor each medication has a corresponding diagnosis in Point Click Care 3. Bi-weekly meeting with provider, pharmacist, and DON to address medication irregularities 4. Immediate notification process for potential clinically significant medication-related concerns 5. Monthly Quality Assurance review of compliance with Drug Regimen Review requirements Staff Education The consultant pharmacist and Director of Nursing provided education to licensed nurses and providers, which included: 1. CMS requirements for F756 2. Monthly Drug Regimen Review process 3. Documentation requirements 4. Physician response requirements 5. Tracking and follow-up of pharmacist recommendations ---Completed 07/09/2026 Attendance records will be maintained. Monitoring The Director of Nursing/Pharmacist: 1. Audit 5 resident records weekly for 4 weeks to verify: a. Monthly pharmacist review completed b. Recommendations communicated appropriately c. Physician response documented d. Recommendations resolved timely. 2. Then audit 10 resident records monthly for 2 additional months.		

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F0756 SS = E	Continued from page 79 She had a 4/17/26 physician's order for lorazepam 1 mg (an anti-anxiety medication) one tablet to be administered every eight hours as needed for anxiety. There was no end date on that physician's order. She had a 4/21/26 physician's order for lorazepam 1 mg one tablet to be administered two times per day. There was no diagnosis or indication for use identified for this medication. She had a 4/21/26 physician's order for olanzapine 10 mg (an antipsychotic medication) one tablet to be administered two times per day for dementia with agitation and a 4/25/26 physician's order for quetiapine 50 mg (an antipsychotic medication) administer one tablet in the afternoon for agitation. Olanzapine and quetiapine were in the same drug class. A 4/21/26 progress note from medical director L indicated he had spoken with an on-call psychiatrist about resident 32's suicidal ideations and that psychiatrist recommended "transitioning away from scheduled Seroquel (quetiapine) and switching to scheduled olanzapine." 4. Review of resident 32's 5/29/26 monthly medication review revealed licensed pharmacist M documented, "There are no medication-related concerns at this time." The monthly medication review identified that the physician ordered psychotropic medications as mirtazapine 7.5 mg at bedtime, olanzapine 10 mg two times per day, lorazepam 1 mg two times per day, and quetiapine 25 mg three times per day as needed. "Quetiapine will require 2 GDR [gradual dose reduction] attempts prior to 4/27 (Jul, Nov). PRN [as needed] use should be limited to 14 days and will require reassessment." "Therapy changed to Olanzapine 10 mg BID [two times a day] given with lorazepam 1 mg BID per geriatric psychiatry recommendation." The monthly medication review did not address that the indication for use of mirtazapine was depression and resident 32 did not have a diagnosis of depression in her EMR. It did not address the as needed lorazepam that did not have an end date on the physician's order or the scheduled lorazepam not having a diagnosis on the physician's order. It identified quetiapine as being ordered to be given three times per day as needed, and the physician's order was for it to be administered daily in the afternoon. The monthly medication review did not identify the duplicate therapy of olanzapine and quetiapine or the psychiatrist recommended a transition from quetiapine to olanzapine.	F0756	Audit results will be presented to the facility's Quality and Performance Improvement (QAPI) Committee monthly. The committee will review trends, identify opportunities for improvement, and implement additional corrective actions as needed until sustained compliance is achieved by the pharmacist. Completion Date All identified deficiencies will be corrected by July 9, 2026. This will be taken to QAPI each month, and will be ongoing with no end date.	

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F0756 SS = E	Continued from page 80 5. Review of resident 21's EMR revealed he was admitted to the facility on 10/23/25. His 4/21/26 Brief Interview of Mental Status (BIMS) assessment score was 3, 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), dementia (a group of symptoms affecting memory, thinking, and social abilities) with agitation and behavioral disturbance, and neurocognitive disorder with Lewy Bodies (a progressive brain disorder caused by abnormal protein clumps that damage nerve cells that affects thinking, memory, movement, sleep, and behavior), and obstructive sleep apnea (a disorder when your breathing repeatedly stops and starts during sleep because the throat muscles relax, causing the airway to collapse and block airflow). He had a 10/23/25 physician's order for temazepam 15 milligrams (mg), a sedative-hypnotic medication that helps the brain relax, making it easier to fall asleep, one tablet by mouth every 24 hours PRN (as needed) at bedtime for insomnia (a sleep disorder with trouble falling asleep, staying asleep, or waking too early). Resident 21's EMR did not document a 14-day stop date from initiation and did not document a physician evaluation with a rationale for continuing resident 21's temazepam beyond 14 days. No physician response was documented for a GDR for that medication. He had a 10/23/25 physician's order for trazodone 100 mg (an antidepressant medication), one tablet by mouth at bedtime for insomnia. Resident 21's EMR did not document a physician evaluation with a rationale for continuing resident 21's trazodone, and no physician response was documented for a GDR for that medication. He had physicians' orders dated 10/24/25 for lorazepam Intensol oral concentrate 0.25 milliliters (mL) (an antianxiety medication) by mouth every two hours PRN (as needed) for agitation and for 0.5 mL by mouth every two hours PRN for agitation. Resident 21's EMR did not document 14-day stop dates from the initiation of both doses, nor did it document evaluations by the physician with rationales for continuing Resident 21's lorazepam doses beyond their 14-day limits.			F0756			

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F0756 SS = E	Continued from page 81 Licensed pharmacist M completed monthly Drug Regimen Reviews (DRRs) on 1/26/26, 2/27/26, 3/30/26, 4/29/26, and 5/29/26. A request to evaluate resident 21's lorazepam orders was suggested on 1/26/26 by licensed pharmacist M. The 5/29/26 review note completed by licensed pharmacist M indicated that resident 21's lorazepam was discontinued by the physician. A 1/30/26 order note for resident 21 indicated that a physician's order was received to discontinue his lorazepam. Review of resident 21's active orders revealed that resident 21 continued his lorazepam Intensol oral concentrate 0.25 mL by mouth every two hours PRN and lorazepam 0.5 mL by mouth every two hours PRN, both for agitation, and remained active since 10/24/25. No documentation was found indicating that the lorazepam doses were discontinued on 1/30/26. He had physicians' orders dated 4/2/26 for sertraline 100 mg (an antidepressant medication), 1 tablet by mouth in the morning and 50 mg (1/2 tablet) at bedtime for depression (a mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities). He did not have a diagnosis of depression. 6. Review of resident 6's EMR revealed he was admitted to the facility on 11/17/25. His 5/14/26 BIMS assessment score was 5, which indicated his cognition was severely impaired. His diagnoses included type 2 diabetes mellitus (a condition involving disruptions in how the body regulates blood sugar), peripheral vascular disease (a circulation disorder characterized by the narrowing, blockage, or spasms of blood vessels outside of the heart and brain), chronic kidney disease (loss of the kidneys' ability to filter waste and excess fluid from the blood), cerebral infarction (stroke), repeated falls, weakness, and tremor (involuntary, rhythmic shaking or trembling movement). He had an 11/13/25 physician's order for Sertraline HCl oral tablet 100 mg (an antidepressant medication used to treat mental health conditions like major depressive disorder), give 100 mg by mouth in the morning for depression. Resident 6 had a 1/23/26 physician's order for Haldol 5 mg (an antipsychotic medication; a drug that alters neurotransmitter activity in the brain to	F0756		

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F0756 SS = E	Continued from page 82 reduce symptoms of mental health conditions): "give 10 mg by mouth every 6 hours as needed for agitation." That physician's order did not have an end date, and he needed to be seen by a physician to have this reordered on 2/8/26. There was no diagnosis for use identified for this medication. He had a 2/20/26 physician's order for Seroquel 25 mg (an antipsychotic medication), one tablet by mouth two times a day for agitation. The behaviors that Seroquel was ordered to treat were not identified. There was no diagnosis for use identified for this medication. Review of resident 6's 11/17/25 through 5/29/26 DRRs and gradual dose reduction recommendations revealed that on 11/17/25, the DRR did not address that he took an antidepressant medication and did not have a diagnosis of depression in his EMR. On 12/29/25, the DRR indicated there were no medication-related concerns at this time. The DRR did not address that he took antidepressant medication and did not have a diagnosis of depression in his EMR. On 1/28/26, the DRR indicated there were no medication-related concerns at this time. The DRR did not address that he took antidepressant and antipsychotic medication and did not have a diagnosis of depression, or another mental health disorder, agitation, or anxiety in resident 6's EMR. On 2/27/26, the pharmacist's recommendation included "The following medication-related concern has been identified: 1) Evaluation of PRN psychotropic medication: [Resident 6] has an active orders for Haloperidol 10 mg Q6H [every six hours] PRN agitation/anxiety. Per CMS [Centers for Medicare & Medicaid Services] guidelines, non-pharmacological interventions are prioritized and use of PRN psychotropic medications is limited to 14 days. Evaluation by a physician is required to extend use beyond 14 days. Provider contacted to complete the risk-benefit evaluation for ongoing use." The DRR did not address that resident 6 took antidepressant and antipsychotic medication, and he did not have a diagnosis of depression, or another mental health disorder, agitation, or anxiety in his EMR. There was no documentation that the provider followed up on the pharmacist's recommendation. On 3/30/26, the pharmacist's recommendation included "The following medication-related concern	F0756			

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F0756 SS = E	Continued from page 83 has been identified: 1) Gradual Dose Reduction: [Resident 6] is currently taking Sertraline 100 mg QAM [every morning] for depression. Per CMS guidelines, this medication requires GDR attempts with the intent of utilizing [the] lowest possible effective/optimal dose. Provider contacted to complete a Gradual Dose Reduction Risk-Benefit Evaluation." There was no documentation that the provider followed up on the pharmacist's recommendation. The 3/30/26 DRR did not address that he took antidepressant and antipsychotic medication, and he did not have a diagnosis of depression, or another mental health disorder, agitation, or anxiety in his EMR. The DRR did not address the as-needed Haldol that did not have a supporting diagnosis or end date on the physician's order. On 4/29/26, the pharmacist's recommendation included that there were no medication-related concerns identified at this time. The DRR did not address that he took antidepressant and antipsychotic medication and did not have a diagnosis of depression, or another mental health disorder, agitation, or anxiety in his EMR. The DRR did not address the as-needed Haldol that did not have a supporting diagnosis or end date on the physician's order, or the need for a GDR of the scheduled Sertraline. On 5/29/26, "The following medication-related concern has been identified: 1) Gradual Dose Reduction: [Resident 6] is currently taking Sertraline 100 mg QAM [every morning] for depression. Per CMS guidelines, this medication requires GDR [gradual dose reduction] attempts with the intent of utilizing [the] lowest possible effective/optimal dose. Provider contacted to complete a Gradual Dose Reduction Risk-Benefit Evaluation." This was noted, and the physician declined the GDR. The DRR did not address that he did not have a diagnosis of depression, or another mental health disorder, agitation, or anxiety in his EMR. The DRR did not address the as-needed Haldol that did not have a supporting diagnosis or end date on the physician's order. 7. Interview on 5/27/26 at 2:43 p.m. with director of nursing (DON) B revealed the provider did not have a policy related to psychotropic medications.	F0756		

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F0756 SS = E	Continued from page 84 8. Interview and EMR review on 6/1/26 at 2:33 p.m. with licensed pharmacist M revealed she reviewed the residents' medication regimen monthly and was responsible for completing the residents' monthly medication review and making recommendations to the physician for the required gradual dose reduction. During her reviews she looked for psychotropic medications that were prescribed as needed to be sure the medication had an end date. If there was no end date, she would send a recommendation to the physician to place an end date on those medications. She acknowledged haloperidol was an antipsychotic and could not be ordered to be administered as needed for longer than 14 days without being seen by a physician and a new physician's order obtained. When she completed the residents' monthly medication reviews, she reviewed the medications to be sure there was a diagnosis associated with the medication. She did not review the residents' diagnoses list in the EMR to be sure the diagnosis assigned to the medication was a diagnosis that resident had. She verified resident 32 did not have a diagnosis of depression but her physician's order for mirtazapine indicated it was being used for depression. Licensed pharmacist M was aware resident 32 had duplicate therapy related to her antipsychotic medications. She thought the duplicate therapy was the recommendation of the geriatric psychiatrist, according to medical director L's 4/21/26 progress note. After reviewing the progress note, licensed pharmacist M stated she had read the progress note wrong previously and medical director L had documented that resident 32 was to be transitioning from quetiapine and switching to olanzapine. She had not made the recommendation to continue with the transition from quetiapine to olanzapine in her monthly medication reviews. 9. Interview on 6/2/26 at 10:01 a.m. with medical director L revealed he received the monthly medication reviews and the gradual dose recommendations from licensed pharmacist M in a secure envelope each month. When he receives the monthly medication reviews and gradual dose recommendations, he reviews them and responds to them if needed. If he had a question related to the monthly medication review or gradual dose reduction recommendation he would talk with pharmacist M in person. If the monthly medication			F0756			

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F0756 SS = E	Continued from page 85 review or the gradual dose recommendation required a new prescription, he would submit the new prescription electronically to the pharmacy and the provider. Medical director L acknowledged he had not responded to a gradual dose reduction recommendation submitted by licensed pharmacist M for resident 6. He expected that if he missed a monthly medication review or gradual dose recommendation, licensed pharmacist M or someone in the nursing department would immediately notify him that it was missed. He expected licensed pharmacist M and someone in the nursing department to review the monthly medication reviews and the gradual dose reduction recommendations to ensure they are completed each month. 10. Interview and EMR review on 6/2/26 at 11:30 a.m. with DON B revealed the provider did not review the risk versus benefit of psychotropic medications, educate on alternatives to the psychotropic medications, or have consent forms signed by the resident's representative prior to starting or changing resident 21's psychotropic medications. There was no documentation that resident 21's representative was notified when he was started on his psychotropic medications. DON B was aware of the regulation related to the consent for the use of psychotropic medications, but had not implemented a process for the review of risk versus benefits, review of alternative treatments or interventions, and consent for psychotropic medications. 11. Interview on 6/2/26 at 12:31 p.m. with CEO A revealed that he was aware the facility lacked a process for residents' use of psychotropic medications, was unaware that consent forms were not being completed for their use, and was unaware that appropriate diagnoses were not consistently documented. He was unaware that licensed pharmacist M's recommendations were not reaching medical director L, and, as a result, the provider did not implement them for several months. He acknowledged that resident diagnoses were not consistently documented in resident records, pharmacy recommendations regarding psychotropic medication management were not implemented in a timely manner, and residents or their representatives were not informed about their psychotropic medication treatment, including risks, benefits, alternatives, and consent prior to initiation or	F0756		

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F0756 SS = E	Continued from page 86 continuation of their medications. 12. Review of the provider's revised November 2024 Drugs: Review of Orders For Discontinuation policy revealed that "A procedure whereby the dosage and schedule of medications will be reviewed by physicians." "The timeframe for review of orders for continuation or discontinuation will apply to the following categories: a. Controlled Substances =30 days. b. Antibiotics = 7 days. c. Anticoagulants = 30 days. d. Colchicine for acute gout attack = 48 hours e. Ketorolac (Toradol) = 5 days. f. All other drugs not otherwise ordered for a specific time or number of doses = 60 days." "The medication needing review will not automatically discontinue and will remain active until discontinued by the physician." "The physician will have three options under this activity: 1. Review – this will reset the review date for the medication. 2. Discontinue – this will discontinue the medication. 3. Modify – this will modify the medication order and reset the review date." Psychotropic medications were not included in the policy to include PRN (as needed) orders and their 14-day stop dates. 13. Review of the provider's 1/12/26 Behavioral Health Management policy revealed, "Staff will proactively assess, monitor, and manage behavioral symptoms using individualized, nonpharmacological and clinically appropriate interventions while ensuring resident dignity, safety, and regulatory compliance." The use of psychotropic medications, "Must comply with CMS [Center for Medicare and Medicaid Services] regulations (gradual dose reductions, indications)." "Use only when clinically necessary			F0756			

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F0756 SS = E	Continued from page 87 and not for staff convenience." Requires: Documented clinical indication, provider order, and monitoring for effectiveness and side effects. 14. Review of the provider's 12/30/25 Facility Assessment Tool revealed, "Our facility has an excellent consultant that does thorough chart reviews, makes appropriate suggestions, he is instrumental in helping with medication audits and accuracy." 15. A Monthly Medication Review and a Gradual Dose Reduction policy were requested on 6/2/26 at 9:20 a.m. and was not received by the end of the survey.	F0756		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review, the facility failed to ensure timely destruction of controlled medications (medications	F0761	-Any medications identified during the survey as improperly labeled or stored were immediately corrected. -Medications without proper labeling (including resident name, drug name, strength, expiration date, or beyond-use date) were removed and either relabeled appropriately or disposed of per facility policy. -Medications found to be stored improperly (e. g., incorrect temperature, unsecured areas) were immediately relocated to appropriate storage areas. -Refrigerated medications were reviewed, and temperatures were verified to be within acceptable ranges. Any discrepancies were addressed immediately. --A 100% audit of all medication storage areas was conducted, including: ---Medication rooms ---Refrigerators ---Treatment carts and storage areas --The audit included: --Proper labeling of all medications --Expiration date checks --Appropriate storage conditions (temperature, light, security) --Any identified concerns were corrected immediately. --All expired items in the medication room were discarded	7/9/2026

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F0761 SS = E	Continued from page 88 with risk for abuse and addiction) for six of six sampled residents (7,8,11,13, 32, and 100) and failed to ensure that the controlled medications awaiting destruction were stored with restricted access and maintained under proper accountability procedures in one of one medication storage room. Findings include: 1. Observation and interview on 5/27/26 at 3:31 p.m. of the medication storage room with contracted travel registered nurse (RN) V revealed that the door was locked and that she used a key to enter. She stated that she held the key to the medication storage room for her shift and that every nurse had access to the medication room key during their shifts at the facility. The resident's medication refrigerator contained resident's personal beverages and their medications stored together. Resident 5's Trulicity 3mg/0.5ml syringe box was wet, as two boxes of opened, unlabeled wine boxes were stored above the medications. One box of wine was leaking from the spicket. Contracted travel RN V acknowledged that the cardboard medication container for resident 5's medication was wet. There was an unlabeled 12-pack of beer stored in the refrigerator as well. Additionally, a clear plastic bag containing three boxes of influenza vaccine Adjuvanted on the bottom shelf was wet. The following expired medications and supplies were stored on shelves in the medication storage room: • Eight boxes of COVID-19 Antigen Rapid Tests (5-test kits), expired 9/2/25 • One box (50 per box) Bionix lighted ear cures, expired 11/7/25 • Twenty-four boxes of COVID-19 Antigen Rapid Tests (2-test kits), expired 11/11/25 • Nine PureWick female external catheters, expired 4/28/26 • Five syringes of Influenza vaccine adjuvanted lot #407253, expired 5/6/26 • Eight syringes of Influenza vaccine adjuvanted lot #407257, expired 5/13/26			F0761	-Education will be provided to all licensed nurses and applicable staff at a mandatory meeting and will be completed by July 9, 2026. Any staff unable to attend will receive education prior to their next scheduled shift. -A process has been implemented to ensure medications are destroyed within one week of being discontinued or identified for disposal. All medications that were awaiting destruction were properly destroyed on May 29, 2026, and this new process will be followed moving forward. -Temperature logs for the medication refrigerator were initiated on June 4, 2026, and will be maintained daily to ensure proper storage conditions. -All resident wine and alcoholic beverages were removed from the medication refrigerator to ensure appropriate and compliant use of medication storage areas. -The Director of Nursing (DON) and/or Assistant Director of Nursing (ADON) will complete weekly audits for four (4) weeks, then monthly for three (3) months to ensure ongoing compliance. Any identified concerns will be addressed immediately with re-education and corrective action as indicated. Findings will be reviewed through the QAPI process. Systematic Changes to Prevent Recurrence: The facility has implemented the following measures: --Implemented a Controlled Substance Diversion Prevention Policy --Established procedure to restrict access to unused, expired, and discontinued controlled substances. --Enhanced medication storage security of unused, expired, and discontinued controlled substances, including logging and storage of controlled substances needing destruction in a tamper-evident container --Implemented controlled medications held for destruction shift checklist		

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F0761 SS = E	Continued from page 89 Contracted travel RN V acknowledged that the medications and supplies had expired and should have been removed from the medication storage room during the last monthly check. She acknowledged that residents' personal food and drinks should not be stored in the medication refrigerator due to the risk of contamination. She acknowledged that resident 5's medication container was compromised from the leaking wine spicket. Contracted travel RN V stated that controlled medications waiting to be destroyed were stored in the locked cupboard in the medication storage room. She was unsure of the medication destruction process. 2. Observation and interview on 5/27/26 at 4:14 p.m. with assistant director of nursing (ADON) C in the medication storage room revealed that outdated medications and supplies in the medication storage room were checked by night shift nurses the last day of the month, and nurses were expected to complete a fax request to the pharmacy to notify them that medications and supplies had expired and needed to be replaced. The resident medication refrigerator temperatures were to be monitored by the nurses every shift. She acknowledged that resident 5's cardboard medication container was wet from a leaking wine box stored above the medications. She was unsure if the resident's personal food and drinks could be stored in the medication refrigerator. ADON C acknowledged that two boxes of wine and a 12-pack of beer were not labeled with the resident's name or the date the wine boxes were opened. 3. Observation and interview on 5/27/26 at 4:19 p.m. with director of nursing (DON) B, in the medication storage room, revealed that temperatures should be monitored once or twice a day, but she was unsure. She acknowledged that no temperature log was maintained for May 2026. Temperature logs for February, March, and April 2026 were reviewed and revealed numerous missing temperature readings. She stated that the controlled medications were locked in a 2-door cupboard and that she, ADON C, and the scheduled working nurses had access to the key. DON B said that controlled medications were destroyed together by ADON C and licensed pharmacist M every one to two weeks. She said the controlled medications awaiting destruction were not counted each shift. 4. Review of the provider's resident medication	F0761	Staff Education 1. All licensed nurses, medication aides, and applicable staff will receive education on the Controlled Substance Diversion Prevention Policy and will be mandatory in the on-boarding for all staff. Monitoring and Quality Assurance 1. The Director of Nursing, Assistant Director of Nursing, or designee will conduct: - Weekly audits of controlled substance held for destruction records - Biweekly audits for the following 2 months - Monthly audits thereafter for an additional 3 months 2. Audit results will be reviewed at the facility's Quality Assurance and Performance Improvement Committee meetings 3. Any identified concerns will result in immediate corrective action additional staff education, and follow-up monitoring. 4. Compliance trends and audit findings will be tracked and documented to ensure sustained improvement. All corrective actions will be completed by July 9, 2026.	

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F0761 SS = E	Continued from page 90 refrigerator temperature log revealed that "The temperature of patient medication refrigerators is to be monitored and documented daily." "Store the medications under proper conditions as soon as possible and contact the pharmacy to determine if the potency of any of the medications has been affected, and recommendations for use or disposal." "If pharmacy recommends, dispose of open multiple-use vials of medication." " Defrost immediately if needed." "Notify maintenance for recommendation regarding repair/maintenance/replacement." "Document the actions taken in the space provided on the back of this sheet." The February 2026 temperature log had missing temperature documentation on days 2, 6-7, 11-15, 18, 20-21, and 24-27. The March 2026 temperature log had missing temperature documentation on days 4-7, 14, 18-21, and 26-28. The April 2026 temperature log was missing temperature documentation every day except days 5 and 6. 5. Interview on 5/28/26 at 8:40 a.m. with RN Q revealed she was concerned about the number of controlled medications awaiting destruction. She reported there were numerous controlled medications in the locked cupboard in the medication storage room awaiting destruction with licensed pharmacist M and ADON C. RN Q stated that the controlled medications had been in the cupboard for several weeks, waiting to be destroyed. 6. Observation and interview on 5/28/26 at 11:46 a.m. with ADON C in the medication storage room, and the controlled medications revealed that the controlled medications were locked in a cupboard in the medication storage room. Numerous controlled medications were stored in the cupboard, and the cupboard was disorganized and did not have a clear system of order. The controlled medication disposition forms were not stored with the medications, requiring ADON C to search through the cupboard to match each medication with its corresponding form. She stated that the controlled medications were to be counted and then destroyed at least every one to			F0761			

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F0761 SS = E	Continued from page 91 two weeks. ADON C stated that she and licensed pharmacist M were usually the ones who counted and destroyed the controlled medications together, and that they had not done so in over 2 weeks. She acknowledged that controlled medications awaiting destruction were not counted daily for their accountability, and multiple staff nurses having access to them was a potential risk for diversion. She stated that all medications were destroyed in the RX Destroyer (a liquid, ready-to-use chemical drug destruction product that begins deactivating drugs upon contact with it). Review of destruction logs revealed that she and licensed pharmacist M last counted together on 3/14/26. She acknowledged that the controlled medications had not been destroyed by her and licensed pharmacist M for over two months. The cupboard contained the following unreconciled controlled medications awaiting destruction for residents 7, 8, 11, 13, 32, and 100: Resident 7: • Eight tablets of lorazepam 0.5 mg • Six tablets of lorazepam 0.5 mg • Six tablets of lorazepam 0.5 mg PRN • 29 mL of lorazepam Intensol 2 mg/mL • Two tablets of diazepam 10 mg • 25 mL of morphine sulfate oral solution 20 mg/mL Resident 8: • 21 mL of lorazepam Intensol oral concentrate 2 mg/mL • 75 tablets of hydromorphone 2 mg • 26 mL of morphine sulfate 100 mg/5 mL • 15 tablets of morphine sulfate ER 60 mg • 15 tablets of morphine sulfate ER 60 mg Resident 11: • One tablet of buprenorphine 2 mg	F0761					

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F0761 SS = E	Continued from page 92 Resident 13: • 15 tablets of hydrocodone/APAP 5–325 mg • 26 tablets of tramadol 50 mg • 22.5 mL of morphine sulfate 20 mg/mL • Nine fentanyl 25 mcg/hr patches Resident 32: • Three tablets of haloperidol 5 mg • One tablet of lorazepam 1 mg Resident 100: • 28.5 mL of morphine sulfate oral solution 20 mg/mL • Five fentanyl 25 mcg/hr patches • 29.25 mL of lorazepam Intensol oral concentrate 2 mg/mL Unknown • Two unidentified light-orange pills, stored in an unlabeled clear plastic medication cup. 7. Interview on 5/28/26 at 12:28 p.m. with ADON C revealed that DON B reported to her that DON B found medications on the floor in former resident 8's room, but she was unsure of the exact date. She stated that DON B said the medication was brought to resident 8 by a family member or friend. ADON C acknowledged that the medication was not documented on a controlled log sheet, was stored without identification, and that she had no record of it being stored in the medication room cupboard. 8. Interview on 5/28/26 at 1:45 p.m. with DON B in the medication storage room revealed that she acknowledged that resident 5's cardboard medication container was wet and that two boxes of unlabeled, opened wine above were likely what had leaked onto the medication. She removed both open boxes of wine, placed them in the sink, and stated she would discard them. She removed a 12-pack of beer from the door of the medication refrigerator that was not labeled with a resident's name.	F0761			

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F0761 SS = E	Continued from page 93 She acknowledged that residents' personal food and beverages should not be stored in the medication refrigerator but should be placed in the hospitality refrigerator behind the nurses' station. She expected nursing staff to complete a thorough check of the medication storage room for expired medications and supplies monthly and dispose of them. She acknowledged that controlled medications awaiting destruction were not counted each shift for accountability, that every nurse who worked a shift had access to the keys for both the medication storage room and the cupboard. She agreed that the controlled medications had not been destroyed by ADON C and licensed pharmacist M for over two months. Additionally, she said that maintenance had access to the medication storage room and acknowledged there was potential for drug diversion. 9. Interview on 6/1/26 at 2:32 p.m. with licensed pharmacist M revealed she had been with the facility for one year and completed resident chart reviews, managed daily medication refills, and destroyed controlled medications with ADON C. She said that three months ago, she and ADON C changed to routinely destroying medications every other Tuesday to limit the number of controlled medications stored for destruction. Prior to that change, it was the facility contacting the pharmacy to come and destroy the controlled medications when needed. She said that RX Destroyer was used for the destruction of the controlled medications. Licensed pharmacist M was unsure whether another RN could destroy medications with her if ADON C was not available, and said she would have to ask DON B. She stated that she was at the facility frequently but did not have keys or access to the medication room or the locked cupboard that stored the controlled medications awaiting destruction. She was unsure if the controlled medications awaiting destruction were reconciled every shift until destroyed. She stated that there was concern for potential diversion when numerous people had access to keys. Licensed pharmacist M said that it was the nurses' responsibility to go through the medication room and carts for expired meds and supplies, and acknowledged that resident food and beverages should not be stored in the medication refrigerator. She acknowledged that waiting over 2 months to destroy controlled medications was not good practice and was a concern for potential drug diversion as well. She stated that she had not been involved in the facility's pharmacy policymaking.	F0761		

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F0761 SS = E	Continued from page 94 10. Interview on 6/2/26 at 11:48 a.m. with DON B revealed that the unidentified medication that was stored in the locked cupboard in the medication room belonged to former resident 8 and was Dilaudid 2mg (an opioid medication used to treat moderate to severe pain) tablets that were brought in from home by his family or a friend. She acknowledged that the medication was not documented on a controlled log sheet, was stored in the cupboard unidentified, and she had no record of it being in the medication room cupboard. DON B didn't think about the medication being counted and destroyed because it was not a medication from the facility. She did not remember whether she documented the medication information in resident 8's EMR. 11. Interview on 6/2/26 at 12:31 p.m. with chief executive officer (CEO) A revealed that he expected nursing to go through the medication room monthly to check for expired medications and supplies and dispose of them. He stated that the controlled medications should be counted and then destroyed by licensed pharmacist M and ADON C when necessary. He was not aware that the controlled medications were not destroyed on a routine basis. He was not aware that the controlled medications had not been destroyed for over two months. He acknowledged that nursing staff have access to the keys to the medication storage room and the locked cupboard containing controlled medications awaiting destruction. He also confirmed that maintenance has a key and access to the medication storage room. 12. Medication storage, resident medication refrigerator, drug diversion, consultant pharmacist, and pharmacy services policies were requested between 5/27/26 and 6/2/26 during the survey; the facility did not have those policies for review. 13. Review of the provider's revised August 2018 Outdated Drug Control policy revealed that "Outdated medications will not be dispensed for patient use or allowed to remain in the dispensing area of the pharmacy or in patient areas." "Pharmacy personnel will check medications for dated items and remove all outdated packages from the shelves monthly." "Nursing stations and medication stock areas will be checked monthly for outdated items and replaced." "All outdated inventory will be removed and replaced by the pharmacy."			F0761			

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F0761 SS = E	Continued from page 95 14. Review of the provider's reviewed September 2018 Drug Disposition and Destruction policy defined the "Procedure for proper disposition of medicines, which are discontinued because of the discharge or death of a resident; the drug is outdated; a drug is found that is not identifiable to a resident; the prescription is discontinued or changed; or destruction of a partial dose is required." "Schedule II, III and IV drugs [controlled medications] (medications with risk for abuse and addiction) will be destroyed by a pharmacist and a registered nurse (RN)." "Discontinued medications (excluding Schedule II, III, and IV drugs) may be kept up to one month after the discontinued date." "Destroy medications immediately if: resident was discharged or has expired." "Discontinued Schedule II, III, and IV drugs will be secured, and then destroyed as soon as the pharmacist is available." "Drugs with the exception of morphine oral solution and fentanyl patches, will be crushed and mixed in kitty litter in med room by the pharmacist and an RN and discarded." "Morphine oral solution and fentanyl will be flushed down the toilet." "Unless otherwise instructed, flush tablets, capsules, liquids, and contents of vials and ampules down the toilet." "If a drug is found that cannot be readily identified to a resident, the drug will be taken to a pharmacist for identification." "If the drug cannot be traced to a resident, it will be destroyed." "An attempt will be made to identify the resident and why the drug was not properly administered." "A documentation note will be written in the resident's medical record (Medication Reconciliation Form) by the person responsible for destroying the medications." "The note will be signed by those persons destroying the medications." "The drug disposition record must contain, as a minimum, the following information: date destroyed, name of the drug, dosage of drug, prescription number (if any), the quantity destroyed, method of destruction, and signatures of witnesses." "Completed drug disposition records must be forwarded to medical records for the resident's medical record." 15. Review of the provider's undated Admission Packet revealed that with food and beverages, "Family and friends may bring in food and non-alcoholic beverages as approved by the physician's ordered diet. Please report any food and beverages brought in. Alcoholic beverages are	F0761		

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F0761 SS = E	Continued from page 96 permitted only with a doctor's order and are kept in the medication room. Refrigerator space is available for small food and drink items in the facility nourishment room."	F0761		
F0944 SS = E	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the staff received the required training regarding the elements and goals of the facility's Quality Assurance and Performance Improvement (QAPI) program for five of five employees reviewed (G, O, R, Y, and Z). Findings include: 1. Review of employee personnel records revealed dietary manager G was hired on 7/28/25. Certified nursing assistant (CNA) O was hired on 2/15/26. Contracted travel CNA Z was hired on 4/6/26. Housekeeping aide Y was hired on 4/7/26. Contracted travel licensed practical nurse (LPN) was hired on 4/27/26. There was no documentation to support employees G, O, R, Y, and Z received training regarding the elements and goals of the facility's QAPI program. 2. Interview on 6/2/26 at 11:48 a.m. with director of nursing (DON) B revealed she managed the QAPI meetings. The staff were informed about any performance improvement plans (PIPS) developed in QAPI by their department manager. The staff did not receive any training regarding the elements and goals of the facility's QAPI program. 3. Interview on 6/2/26 at 9:15 a.m. with human resources director J revealed she was responsible for assigning required training for the staff and the staff were not assigned training related to the QAPI program. She was not aware that the elements and goals of the facility's QAPI program was a required training topic. 4. Interview on 6/2/26 at 12:31 p.m. with chief	F0944	Education on QAPI was deployed through the Winner Regional Health training system and will be completed by 7/9/26 HR will report on any Winner Long Term care employees at monthly QAPI meetings to maintain 100% compliance And all staff will be educated by 7/9/26 QAPI training will be audited monthly for 1 year and will be presented to QAPI • Weekly audits x 4 weeks, then • Monthly audits x 3 months, then • Quarterly thereafter	7/9/2026

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F0944 SS = E	Continued from page 97 executive officer (CEO) A revealed he acknowledged there was required training that was not completed by the staff. 5. Review of the provider's August 2018 Required Annual Training of Long-Term Care Healthcare Workers policy revealed that training was to be completed in accordance with state and federal regulations. The provider "shall maintain a formal orientation program and an ongoing education program for all personnel..." The elements and goals of the facility's QAPI program was not included as required staff training in the policy.	F0944		
F0947 SS = E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is NOT MET as evidenced by: Based on personnel record review, interview, and review of the director of nursing (DON)'s job description the provider failed to ensure yearly performance evaluations were completed on three of three sampled certified nursing assistants (CNAs) (S, U, and AA) and their in-service training was tailored to address areas of weakness as determined in the nurse aide's performance reviews and facility	F0947		

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

FORM APPROVED

OMB NO. 0938-0391

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F0947 SS = E	Continued from page 98 assessment. Findings include: 1. Review of contracted travel CNA S's personnel record revealed she was hired on 3/19/24. There was no yearly performance review in her personnel record. 2. Review of contracted travel CNA U's personnel record revealed she was hired on 3/7/23. There was no yearly performance review in her personnel record. 3. Review of CNA AA's personnel record revealed she was hired on 1/15/08. Her last performance evaluation was on 4/2/25. 4. Interview on 6/2/26 at 10:31 a.m. with director of nursing (DON) B revealed she completed yearly performance evaluations on the provider's nursing staff. She stated that for the contracted travel CNAs, she provided feedback to their travel agency, and she expected the travel agency to complete their yearly performance evaluations. If a CNA was identified to need additional training in an identified area, that training could be added to the basic required training as needed. 5. Review of the provider's undated DON job description revealed, "The DON has a primary roll in the evaluation and improvement of nursing and other services provided. Provides effective onboarding, education, and training to assure [ensure] staff competencies. Provides ongoing coaching, mentoring, and performance feedback for staff to succeed. 6. Review of the provider's 12/30/25 Facility Assessment revealed, "Annual Evaluations- We have implemented an evaluation form that is easier for employees and directors to utilize. We have found it enables more substantial dialogue between the director and staff members."			F0947	No residents were identified as being directly affected by this deficient practice. Employee U is no longer employed with the facility. Human Resources audited Employee AA and confirmed that a yearly evaluation was completed with appropriate signatures on 3/20/2026. Human Resources conducted a review of employee files, to ensure annual evaluations were completed as required. Any missing evaluations were identified and scheduled for completion. · Evaluations will be completed on all travel staff who have been employed for one year or longer · All outstanding evaluations for travel staff will be completed by 7/9/2026 · Human Resources maintains a tracking system for employee evaluations and the ADON/designee will maintain a tracking system for travel staff evaluations · Human Resources sends monthly reminders at the beginning of each month to managers/directors identifying evaluations due Monitoring will include: · Monthly review of evaluation tracking logs by Human Resources · Verification that evaluations are completed timely Audits will be conducted: · Monthly x 3 months · Quarterly x 2 quarters Results will be reviewed in QAPI, and corrective action will be taken as needed. Education will be completed on 07/09/2026		07/09/2026
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances.			F0585			

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F0585 SS = D	Continued from page 99 §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal	F0585	All staff will review Grievance Policy and will receive education on the facility's grievance policy, including recognizes grievances, documentation requirements, reporting expectations, investigation procedures and required time frames for resolution by day 5. **The Grievance Policy will be reviewed during new employee orientation and annual education ** Residents will be educated at each Resident Council of their right to file grievances and where to find the grievance forms ** The facilities grievance process will be reinforced at staff meetings to ensure all staff understand that any verbal or written complaint that alleges dissatisfaction may constitute a grievance. ** The Admission Agreement, Grievance Policy and Grievance Procedure Form will be updated with correct Grievance Official information. The new Grievance Official completed on-line training on 07/14/2026. On 5/27/2026 the Grievance Binders in the 200 and 300 wing were lowered to be wheel chair accessible. The binders were also updated with instruction of how to file a Grievance. Auditing: The Administrator or designee will audit all resident complaints and concerns weekly for 4 weeks, then monthly for 2 months to ensure grievances are appropriately documented and investigated The Audit result s will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review. Any identified concerns will result in immediate corrective action and addition staff education as needed. Education to all staff will be complete by 7/9/26 Audits will include: - When Grievance made - When did investigation into Grievance begin - Was it completed within 5 days	07/09/26

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F0585 SS = D	Continued from page 100 agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and policy review, the provider failed to make information available on how to file a grievance, ensure the grievance forms were readily available to residents and their representatives, designate who the grievance official was, and follow their grievance process when one of one sampled residents' (5) representative expressed a concern about an injury. Findings Include: 1. Observation on 5/27/26 at 8:10 a.m. revealed there were no grievance forms or information on how to file a grievance located in the resident care	F0585		

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F0585 SS = D	Continued from page 101 areas, at the nurses' station, near the dining room, or in the activities room. 2. Interview on 5/27/26 at 8:16 a.m. with social services designee (SSD) F revealed she thought that the grievance official was either licensed social worker (LSW) E or chief executive officer (CEO) A. SSD F was responsible for filing the grievances in a binder. She had not assisted any resident or family member in completing a grievance form. There was no grievance, concern, or complaint filed by resident 5's family member regarding the 11/19/25 incident when resident 5 received a hot liquid burn injury 3. Observation and interview on 5/27/26 at 2:12 p.m. with LSW E revealed she was the grievance official until she began working remotely about two years ago. She supervised SSD F and worked at the facility two days per month. SSD F was the grievance official and was responsible for ensuring that the grievances were investigated by the appropriate department, that follow-up occurred with the individual filing the grievance, and that the grievance form was filed and retained for several years. LSW E expected the grievance forms to be located in each hallway where there were resident rooms, outside of the director of nursing (DON) B's office, and outside of the social services office. She confirmed there were no grievance forms located outside DON B's office or in the 300 hallway. The grievance binder in the 200 hallways was located inside a clear file holder that also held trash bags. It was approximately five feet from the floor and did not contain grievance forms. She agreed that residents who required the use of a wheelchair would not have access to those grievance forms. There were grievance forms in a binder near the front door of the facility outside of the social services office. She confirmed that it was not a resident care area and most residents would not have known they were there. She thought that residents could file a grievance anonymously by sliding a form under SSD F's door or by placing it in the box near the front door. LSW E expected that SSD F would have been responsible for handling a family member's concern if it was not a concern that was required to be reported to the South Dakota (SD) Department of	F0585		

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F0585 SS = D	Continued from page 102 Health (DOH). 4. Interview on 5/27/25 at 2:20 p.m. and again at 3:37 p.m. with LSW E and SSD F revealed SSD F read about resident 5's 11/19/25 hot liquid burn injury the following day (11/20/25) in the nurse's progress note. At that time, it was documented that resident 5 spilled her coffee in her lap. She could not recall when she learned that resident 5's daughter stated that she thought the hot liquid burn injury was caused by a staff member. She was unsure if a grievance form should have been completed or if that hot liquid burn injury should have been reported to the SD DOH. LSW E became aware of resident 5's family members' concern that resident 5 received a hot liquid burn injury and that resident 5's family member thought that a staff member caused that hot liquid burn injury on 12/23/25 when DON B called her several weeks after resident 5 received a hot liquid burn injury from her tea, because a family member complained to the dietitian that staff spilled coffee on resident 5. LSW E was unaware when resident 5's family member first shared the concern that the hot liquid injury was caused by a facility staff member. LSW E expected that if resident 5's family member shared a concern with any staff member that she thought that a staff member caused resident 5's hot liquid burn injury, that a grievance form would have been completed, and that concern would have been reported to CEO A and DON B immediately. 5. Resident Council group interview on 5/27/26 at 2:45 p.m. revealed that three residents attended. The three residents who attended did not know how to file a grievance or where the grievance forms were located. Resident 20 stated that if she had a concern or a grievance, she would tell a nurse and hoped that the nurse would fix the problem. 6. Phone interview on 5/27/26 at 4:34 p.m. with resident 5's family member regarding resident 5's 11/19/25 hot liquid burn injury revealed she visited resident 5 on 11/24/24 and was told by resident 5, "they burned me," and resident 5 showed her the inner thigh area. She was resident 5's emergency contact, and no notification was provided to her or the other listed emergency contact. It had been about a week since that incident occurred. While at	F0585		

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F0585 SS = D	Continued from page 103 the facility on 11/24/25, she spoke with a nurse (she was unable to recall who she spoke with) about the incident and was told that the documentation in resident 5's EMR said that resident 5 spilled her own coffee in her lap and that the emergency contact was notified. She stated that resident 5 was "coherent," repeated several times, "they burned me," and that she believed resident 5. She told the nurse that she thought a staff member caused resident 5's hot liquid burn injury and that she was upset that she and the emergency contact were not notified. She expected someone to follow up with her about her concerns. Resident 5's family member attended the 12/9/24 care conference meeting and told the staff members, again, that she was concerned that a staff member caused resident 5's hot liquid burn injury, and that she and the other emergency contact were not notified. She recalled that registered dietitian (RD) H was present at that care conference and said she would "check into it". On 11/23/25, she "stopped to visit" with RD H because she was not provided any additional information about what happened when resident 5 was burned or what the facility was doing about it. She was frustrated that the facility did not follow up with her about her concerns and stated that she hoped that an incident like this would not happen again or happen to anyone else. 7. Interview on 6/1/26 at 12:17 p.m. and again on 6/2/25 at 11:31 a.m. with DON B regarding resident 5's 11/19/25 hot liquid burn injury revealed that she was notified on 12/22/25 that resident 5's family member was stating that resident 5 was burned by hot liquid and that she thought that a staff member caused the hot liquid burn injury. She was not notified on 11/19/25 that resident 5 received a hot liquid burn injury, and did not expect to be notified because it was not serious enough to require a visit to the emergency room, and staff thought that she spilled her hot tea on herself. She expected the staff in attendance at resident 5's care conference on 12/9/25 to have completed a grievance form when they were notified by resident 5's family member that she was concerned that resident 5 was burned by a staff member with a hot liquid. If a grievance form was filled out, DON B would have been notified, she would have begun an			F0585			

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F0585 SS = D	Continued from page 104 investigation, and would have had the information to follow up with resident 5's family member after the investigation was completed. 8. Interview on 6/2/26 at 8:25 a.m. with RD H regarding resident 5's 11/19/25 hot liquid burn injury revealed she learned of the injury during resident 5's 12/9/25 care conference. She was unsure if a grievance form was completed when resident 5's family member voiced that she was concerned that resident 5 was burned by a staff member with a hot liquid. RD H expected that SSD F would have completed a grievance form if it was appropriate and followed up with resident 5's family after the 12/9/25 care conference. She was surprised when resident 5's daughter visited her again on 12/23/25 and was still concerned about resident 5's 11/19/25 hot liquid burn injury. 9. Interview on 6/2/26 at 9:48 a.m. with SSD F revealed that she attended resident 5's 12/9/25 care conference and was aware that resident 5's family member was concerned about how resident 5 was burned by her hot tea, but it was documented that resident 5 spilled her tea on herself. She was unsure if a grievance should have been completed. She felt that if resident 5's daughter voiced a concern to a nurse on 11/24/25 or to RD H, they would have completed a grievance form if it was appropriate. Nursing or dietary would have been responsible for completing an investigation into those concerns. She was unaware that resident 5's family member had more concerns about resident 5's hot liquid burn injury or how the burn injury happened. After resident 5's 12/9/25 care conference, SSD F expected RD H to have followed up with resident 5's family member about what interventions the facility implemented. Resident 5 spilled her own tea, so she did not think that there was anything else to follow up with the family about. 10. Review of the provider's reviewed December 2021 Filing Grievances/Complaint policy revealed "Our facility will assist residents, their representatives (sponsors), other interested family members, or advocates in filing grievances or complaints when such requests are made." It did not identify who the grievance official was.	F0585			

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F0585 SS = D	Continued from page 105 11. Review of the Provider's undated Grievance/Concern Follow-up form revealed "This form should be completed on any resident comment or criticism not resolved immediately, regarding their care or treatment in any of our facilities. This may come in the form of a resident satisfaction survey, a letter, a phone call, or a conversation with a resident/family member/visitor, etc." 12. Review of the provider's undated Long-Term Care Center Resident Grievance/Concern Procedure revealed "...all residents and/or his/her representative have the right to voice grievances/concerns to the facility..." " Grievance/Concerns can be filed orally or written on the facilities grievance/concern form. (Located in the Grievance/Concern folder outside the social services office or at the end of each wing [hallway])." " We want to ensure prompt resolution of all grievances regarding the resident's rights." The grievance official was listed as LSW E. SSD F's contact information was not included in that procedure.	F0585		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations	F0609	The facility revised and will reinforced the Investigation policy and Abuse education will be completed by 7/9/26 to ensure full compliance with federal and state regulations. System changes include: Abuse Prevention: - Reinforced zero-tolerance policy for abuse, neglect, exploitation, and misappropriation - Staff re-education on recognizing and preventing abuse Immediate Response Requirements: - Ensure resident safety first - Provide medical evaluation and treatment - Remove alleged perpetrator from resident contact +	07/09/2026

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F0609 SS = D	Continued from page 106 to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, observation, document review, record review, and policy review, the provider failed to report within the required time frame to the SD DOH for two of two sampled residents' (5 and 13) allegations of potential resident abuse or neglect. Findings include: 1. Review of the provider's 12/23/25 SD DOH FRI report revealed that on 11/19/25, it was reported that resident 5 spilled her hot tea in the dining room, which resulted in a 0.25 centimeter (cm) blister on her right inner thigh, and both inner thighs were red. Bacitracin (an antibiotic ointment) was applied to the blister, and it was covered with a bandage. Resident 5 told a family member that a staff member spilled the hot tea on her. On 12/22/25, resident 5's family member told registered dietitian (RD) H that she thought that a staff member spilled the hot water on resident 5. On 12/22/25, chief executive officer (CEO) A and director of nursing (DON) B interviewed resident 5, and resident 5 provided inconsistent information about who spilled the hot water for her tea. The provider determined the incident was not the result of abuse or neglect. The report indicated that the "provider, family, and DON" were notified of the incident. 2. A request was made to CEO A on 5/27/26 at 9:00 a.m. for the provider's reporting and investigating policies and incidents subject to reporting. A request was made to DON B on 5/27/26 at 3:00 p.m. for the provider's incident reporting guidelines and abuse and neglect policies. 3. Interview on 5/27/25 at 2:20 p.m. with licensed social worker (LSW) E and social services designee	F0609	Reporting Requirements: · All staff must report allegations immediately to the Charge Nurse, DON, or Administrator · 2-hour reporting for allegations involving abuse or serious bodily injury · 24-hour reporting for all other incidents Required notifications include: - o State Agency - o Law Enforcement (if applicable) - o Physician - o Responsible Party/Family Investigation Process: · Investigations will begin immediately but no later than 24 hours · Assigned to DON, Administrator, or designee · Standardized investigation process includes: - o Interviews (resident, staff, witnesses) - o Record review (medical record, care plan, staffing) - o Environmental review - o Evidence collection Documentation & Conclusion: · All findings documented on standardized Investigation Report Form · Determination: substantiated, unsubstantiated, or inconclusive · Investigations completed within 5 working days or per state requirements Staff Education: · All staff will receive education on: - o Abuse prevention - o Mandatory reporting timelines - o Investigation process - o Risk Management in PCC · Education will be completed by: 7/9/26 Any allegations of Abuse will be taken to QAPI monthly and will be ongoing	

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F0609 SS = D	Continued from page 107 (SSD) revealed SSD F read about resident 5's 11/19/25 hot liquid burn injury the following day (11/20/25) in the nurse's progress note. At that time, it was documented that resident 5 spilled her coffee in her lap. She could not recall when she learned that resident 5's daughter stated that she thought the hot liquid burn injury was caused by a staff member. She could not recall when she learned that resident 5's daughter stated that she thought the hot liquid burn injury was caused by a staff member. LSW E became aware of resident 5's family members' concern that resident 5 received a hot liquid burn injury and that resident 5's family member thought that a staff member caused that burn injury on 12/23/25. LSW E was unaware when resident 5's family member first shared the concern that the hot liquid injury was caused by a facility staff member. She expected that if resident 5's family member shared a concern that she thought that a staff member caused resident 5's burn injury, that concern would have been reported to CEO A and DON B immediately, and CEO A or DON B would have reported the incident to the SD DOH. She expected that CEO A and DON B would have been responsible for filing a report, investigating the incident of concern, and sharing the outcome of their investigation with the family member for a family member's concern that was required to be reported to SD DOH. 4. Continued interview on 5/27/26 at 3:37 p.m. with LSW E revealed that she completed the SD DOH FRI investigation and reports until she began working remotely about two years ago and now CEO A and DON B were responsible for reporting and investigating incidents. She worked at the facility two days per month. She recalled that DON B called her several weeks after resident 5 received a hot liquid burn injury from her tea, because a family member complained to the RD H that staff spilled coffee on resident 5. That incident was originally documented on 11/19/25 by the nurse that resident 5 spilled her hot beverage on herself, and an investigation was not completed. LSW E advised DON B to report the 11/19/25 hot liquid burn injury incident to the SD DOH. 5. Phone interview on 5/27/26 at 4:34 p.m. with	F0609	Education will be completed about State reporting and investigation will be completed on 07/09/2026 at mandatory meeting. Audits will be done by Administrator/DON or designee on all State reports and the audits will be ongoing with every State reportable. All investigation materials will be kept in the investigation binder.	

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F0609 SS = D	Continued from page 108 resident 5's family member regarding resident 5's 11/19/25 hot liquid burn injury incident revealed she visited resident 5 on 11/24/24 and was told by resident 5, "they burned me," and resident 5 showed her the inner thigh area. She was resident 5's emergency contact, and no notification was provided to her or the other listed emergency contact. It had been about a week since that incident occurred. While at the facility on 11/24/25, she spoke with a nurse (she was unable to recall who she spoke with) about the incident and was told that the documentation in resident 5's EMR said that resident 5 spilled her own coffee in her lap and that the emergency contact was notified. She stated that resident 5 was "coherent," repeated several times, "they burned me," and that she believed resident 5. She told the nurse that she thought a staff member caused resident 5's burn injury and that she was upset that she and the other emergency contact were not notified. Resident 5's family member attended the 12/9/24 care conference meeting and told the staff members that she was concerned that a staff member caused resident 5's burn, and that she and the emergency contact were not notified. She recalled that RD H was present at that care conference and said she would "check into it". On 11/23/25, she "stopped to visit" with RD H because she was not provided any additional information about what happened when resident 5 was burned or what the facility was doing about it. She was frustrated that the facility did not follow up with her about her concerns and stated that she hoped that an incident like this would not happen again or happen to anyone else. 6. Review of resident 5's 12/9/25 Care Conference Assessment revealed that resident 5, her family member, RD H, assistant DON C, and SSD F attended that care conference. Resident 5's family member discussed her concerns about resident 5's burn injury from her hot tea. 7. A request was made to DON B on 5/28/26 at 8:30 a.m. for the provider's accident hazards policy. The provider provided their reviewed December 2021 Abuse Investigating policy and their revised January 2020 Accidents and Incidents policy.			F0609			

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F0609 SS = D	Continued from page 109 8. Interview on 6/1/26 at 12:17 p.m. and again on 6/2/25 at 11:31 a.m. with DON B regarding resident 5's 11/19/25 hot liquid burn injury revealed that she was notified on 12/22/25 that resident 5's family member was stating that resident 5 was burned by hot liquid and that she thought that a staff member caused the burn injury. She was not notified on 11/19/25 that resident 5 received a hot liquid burn injury, and did not expect to be notified because it was not serious enough to require a visit to the emergency room, and staff thought that she had spilled her hot tea on herself. She expected the staff in attendance at resident 5's care conference on 12/9/25 would have notified her immediately after resident 5's family member expressed concern that resident 5 was burned by a staff member, so she could have investigated and reported the incident to the SD DOH. Due to the staff not immediately reporting the incident to her, there was a delay in the investigation and reporting of resident 5's hot liquid spill that resulted in a burn, which required treatment. DON B reported resident 5's 11/19/25 hot liquid burn injury to the SD DOH on 12/23/25. She thought allegations of resident abuse or neglect needed to be reported within 24 hours and that her investigation needed to be completed within 5 days. She was not aware that an allegation of resident abuse or neglect needed to be reported within 2 hours. 9. Interview on 6/2/26 at 8:25 a.m. with RD H regarding resident 5's 11/19/25 hot liquid burn injury revealed she learned of the injury during resident 5's 12/9/25 care conference. Resident 5's family member was concerned that resident 5 was burned by hot tea in the dining room, thought that a staff member spilled the hot tea on resident 5, wanted to know more about how the incident occurred, and what steps were taken to prevent it from happening again. RD H stated that she followed up with dietary manager (DM) G, SSD F, and DON B by email after the care conference about the actions that DM G was taking. On 12/23/25, resident 5's family member came to her office, and RD H told her about the implemented interventions. She was unaware whether the incident had been investigated and reported to the SD DOH. 10. Interview on 6/2/26 at 9:48 a.m. with SSD F	F0609		

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F0609 SS = D	Continued from page 110 revealed that she attended resident 5's 12/9/25 care conference and was aware that resident 5's family member was concerned about how resident 5 was burned by her hot tea, but it was documented that resident 5 spilled her tea on herself. She was unsure if a report should have been made to the SD DOH. She was unaware that resident 5's family member had more concerns about resident 5's hot liquid burn injury or how it happened. 11. Review of the SD DOH Facility Reported Incident dated 2/25/26 revealed an allegation of staff abuse by a former contracted travel certified nursing assistant (CNA), BB, against former resident 13 on 2/24/26. On the morning of 2/24/26, at around 6:00 a.m., an unidentified CNA entered resident 13's room to assist her with her morning care. The CNA noted that resident 13 had bruises and a skin tear to her right forearm. The CNA reported her findings to the on-duty unidentified registered nurse. The nurse assessed resident 13 and confirmed that she had bruises on both arms and a skin tear on her right arm. Resident 13 told the CNA and RN that a girl from the night shift was mean, grabbed her arm, and wanted her to get out of bed to go to the bathroom. Resident 13 told the girl (from the night shift) that she had already gone to the bathroom and said no, but the girl had made her get up out of bed. The incident, along with the noted bruising and skin tear, was reported to director of nursing (DON) B upon her arrival at work that same day. On the evening of 2/24/26, DON, B, and the chief executive officer (CEO) A met with the contracted travel CNA BB, to discuss resident 13's abuse allegation. Contracted travel CNA BB explained that she was assisting resident 13 in getting ready for bed on the evening of 2/23/26. While helping resident 13 stand, resident 13 began to fall, contracted travel CNA BB grabbed resident 13 by both forearms to steady her, which may have caused the bruising. Contracted travel CNA BB also stated that when she went in to assist resident 13 with care early the next morning on 2/24/26, resident 13 was combative, but contracted travel CNA BB said she was able to reason with resident 13 and left her room when resident 13 told her to. Contracted travel CNA BB wrote a statement about the incident and was placed on administrative leave pending the investigation. CEO A and DON B interviewed resident 13 regarding her allegation following the meeting held with contracted travel CNA BB, and resident 13's account of the incident did not differ from her previous explanations. A witness statement	F0609			

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F0609 SS = D	Continued from page 111 was obtained by the unidentified CNA that noted the bruising on resident 13's arms the morning of 2/24/26. Law Enforcement was notified by the facility on 2/25/26 at approximately 9:30 a.m. about the abuse allegation and began an investigation. The investigation's conclusion indicated that contracted travel CNA BB was terminated on 2/25/26 and that the facility notified the travel agency because she was no longer allowed on the facility's premises. The report indicated that resident 13's power of attorney (POA), DON, administrator, and physician were notified of resident 13's bruising and the investigation. The Department of Human Services (DHS) and the SD DOH were both notified on 2/25/26. 12. On 5/26/26, a request was made for review of resident 13's facility investigation report from 2/25/26, and on 5/27/26 at 8:12 a.m., CEO A reported that the facility did not have an investigation report to provide. 13. Review of resident 13's electronic medical record (EMR) revealed she was admitted on 7/10/25. Her 12/30/25 Brief Interview of Mental Status (BIMS) assessment score was 4, and her 3/24/26 BIMS assessment score was 7, both of which indicated her cognition was severely impaired. However, she did not have a diagnosis of dementia, Alzheimer's disease, or other cognitive disorder. A nursing progress note dated 2/24/26 at 6:35 a.m. revealed that an unidentified staff member reported to an unidentified nurse that the "resident had 3 large purple bruises on the right forearm." "The bruise closest to the wrist has a small skin tear." "One purple bruise on left forearm." "Left side of lip has a small cut." "Resident states, "She grabbed my arm and twisted it." DON, ADON notified." Resident 13's skin assessment dated 2/24/26 at 12:57 p.m. revealed that she had "3 large purple bruises on her right forearm." "The bruise closest to the wrist has a small skin tear." "One purple bruise on her left forearm, and the left side of her lip has a small cut." "Denies having pain." On 2/24/26 at 3:37 p.m., a progress note indicated			F0609			

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F0609 SS = D	Continued from page 112 that contracted travel RN T was unable to reach resident 13's first emergency contact but was able to reach her second emergency contact by phone, and he would try to notify resident 13's first emergency contact. On 2/25/26 at 1:16 p.m., a progress note indicated that DON B attempted to call resident 13's first emergency contact to "Follow up on bruises", "No answer, will try again later." There was no other documentation in resident 13's EMR indicating that resident 13's emergency contact had been notified of the abuse allegation on 2/24/26 that resulted in physical harm. A physician's order was received twelve days after the incident, on 3/8/26, to "observe bruising to bilateral forearms until healed, two times a day." Review of resident 13's most recent care conference summaries revealed that summaries were completed on 1/5/26 and 3/25/26, but no care conference signature forms were available to review in resident 13's EMR for those dates, so it was unclear if a care conference meeting was conducted. A care conference signature form dated 2/10/26 was reviewed, and it indicated that a care conference had been conducted regarding resident 13's plan of care, but there was no care conference summary available to review in resident 13's EMR for that date. Resident 13's second emergency contact, ADON C, social services designee (SSD) F, activities director (AD) FF, registered dietitian (RD) H, and licensed social worker (LSW) E (by phone) attended that care conference on 2/10/26. There was no documentation in resident 13's EMR that the allegation of abuse with physical harm had been reviewed with the family and IDT team. Resident 13's care plan, dated 7/10/25 and revised on 3/30/26, did not address interventions that ensured she was safe from abuse, including safety measures, physical and emotional support, cognitive or behavioral status, nor did it address follow-up and monitoring. Incident tracking reports in the facility's electronic system (PCC) showed that no incident report for the abuse incident had been completed in the risk management report section, as required by the facility's policy. The dates reviewed to locate the	F0609			

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F0609 SS = D	Continued from page 113 incident were 2/16/26 through 3/16/26, and no documented incident report was found. 14. Review of the facility's working staff schedules and timecard from 2/23/26 through 2/24/26 confirmed that contract travel CNA BB was assigned to resident 13 during the incident period from the night shift of 2/23/26 at 5:17 p.m. through the morning of 2/24/26 at 6:21 a.m. Resident 13's injuries were observed by an oncoming unidentified day shift CNA on 2/24/26, per the facility's SD DOH FRI report. She had noted a skin tear, a cut on the left side of her lip, and significant bruising on both of her arms when she went to assist resident 13 with her morning care on 2/24/26. The unidentified CNA reported her findings to her nurse immediately, and the unidentified nurse responded and completed an assessment, per the facility's SD DOH FRI report. The unidentified nurse documented her findings in a progress note dated 2/24/26 at 6:35 a.m. 15. Review of former contracted travel CNA BB's personnel file revealed that she was hired in January 2024 through a contracted travel agency and that she had completed abuse training online with [contract nursing facility name] on 4/13/23 and also completed elder physical abuse and managing resident behaviors on 9/8/25 through the current facility. No disciplinary actions or allegations of abuse and neglect were documented or found in former contracted travel CNA BB's file. 16. Interview on 5/27/26 at 3:37 p.m. with LSW E revealed that she completed the SD DOH FRI investigation and reports until she began working remotely about two years ago. She worked at the facility two days per month. LSW E said that incident reports were completed by CEO A and DON B and that she was not aware of resident 13's allegation of abuse that resulted in bruising and a skin tear sustained from former contracted travel CNA BB on 2/24/26. LSW E stated she didn't believe she had been notified of the incident involving resident 13 on 2/24/26 and acknowledged that she had not completed any documentation regarding the incident in resident 13's EMR. She expected that CEO A and DON B would have been in charge of filing a report, investigating the incident of concern, sharing the outcome of their investigation with resident 13's first emergency contact and the physician, and reporting to the SD DOH within federal guidelines.	F0609		

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F0609 SS = D	Continued from page 114 17. Interview on 5/28/26 at 4:50 p.m. with CEO A revealed that the provider's investigations for the FRI's were discarded after "about 30 days" if the SD DOH did not come to the facility to investigate the incident. He was unaware that some FRI's would be investigated more than 30 days after the incident. He was not aware of the two-hour report time to the SD DOH for abuse allegations. CEO A thought it was a 24-hour time frame to report to SD DOH and acknowledged that no investigation documents for resident 13 had been completed. CEO A stated, "The employee was terminated, so there was no need for further follow-up." If documentation was completed, such as an incident report, CEO A stated, "I get rid of them [incident reports] after they are sent [to SD DOH], and when the investigation is concluded." CEO A acknowledged that no audits or education were provided to staff, and that no further follow-up was conducted with other residents. He said that incidents were routinely discussed in the Quality Assurance Performance Improvement (QAPI) and board meetings. No incident investigation report from the facility was provided during the survey. 18. Interview on 6/1/26 at 12:08 p.m. with DON B revealed that she or CEO A initiated incident investigations and entered the reports into the state website. DON B said that no audits were completed after the incident involving resident 13 and former contracted travel CNA BB. She acknowledged that no other residents were interviewed to assess additional concerns of abuse or neglect and that no additional education on abuse prevention was provided to staff following the incident. DON B further stated that approximately two weeks prior to resident 13's abuse allegation, another resident (who was unidentified) reported that the same former contracted travel CNA BB had told a resident she could not use the bathroom. DON B said she spoke with the former contracted travel CNA BB, about that allegation, and the CNA denied it. DON B said she reported the information to former contracted travel CNA BB's travel staffing company, identifying the situation as a disciplinary matter. The conversation that DON B had with former contracted travel CNA BB two weeks prior to resident 13's abuse allegation was not found as documented in her personnel file as a disciplinary action or write-up. DON B said she was not aware of any prior abuse or neglect issues involving former contracted travel	F0609		

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F0609 SS = D	Continued from page 115 CNA BB before the incident involving resident 13, except for the above situation. She confirmed receiving a copy of the police report and that notifications were made to the Board of Nursing, Adult Protective Services (APS), and the Ombudsman. When asked about reporting timelines, DON B stated she was unaware that abuse or neglect allegations must be reported within 2 hours. She stated she believed the requirement was 24 hours, with 5 days to complete the investigation. No incident investigation report from the facility was provided during the survey. 19. A phone call was made to contact resident 13's first emergency contact on 5/27/26 at 4:08 p.m.; a message was left for a return call. No return call was received during the survey. 20. Resident 13 was unable to be interviewed as she was discharged on 4/2/26 due to death in the facility. 21. Review of the provider's reviewed August 2018 Incident Reporting policy revealed that "all accidents or incidents occurring on our premises must be reported to the administrator." "Regardless of how minor an accident or incident may be, it must be reported to the charge nurse immediately, and they will report the incident to the department supervisor." "The charge nurse shall notify the medical director, attending physician, and the family of the accident or incident." "A risk management report must be completed on the shift that the accident or incident occurred, and the charge nurse or the department director must conduct an immediate investigation of the accident or incident." "The incident must be reported to the administrator and director of nursing services no later than twelve (12) hours after the occurrence of the accident or incident if any injuries occurred, or within 72 hours if no injuries." "A risk management report is required for any occurrence or event that is out of the ordinary for the resident, or interrupts normal procedure." "Ensure that the care plan is updated if a new intervention is put into place." "Complete the form if any type of abuse occurred (physical, sexual, etc.)." 22. Review of the provider's reviewed October 2021 Incident Reporting Guidelines policy revealed that	F0609					

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F0609 SS = D	Continued from page 116 "Incidents of unusual nature, suspected abuse, medication error, drug reactions, or an accident that causes injury to a resident shall be recorded." "The resident's physician and legal representative shall be notified within 24 hours." "The facility must have evidence that all alleged violations of abuse are thoroughly investigated and prevent further potential abuse while [the] investigation is in progress." "Nurse's notes shall document the incident in sufficient detail in the clinical record." "Document the resident's and witnesses' statements in quotations." "Maintain an incident report log in order to evaluate patterns such as number of incidents per shift or day of the week, types of accidents and injuries, and residents with multiple incidents." "Incident reports must be reviewed by the director of nursing, the Quality Assurance Process Improvement (QAPI)/risk manager, administrator, and medical director." "Incidents will be reported at the monthly LTC (long-term care) QAPI meetings." "Incident reports are filed by time periods (monthly, quarterly, etc.) in SEPARATE FILES from clinical records." "Incident reports are retained according to state statute of limitations and then destroyed according to the same procedures as clinical records." "The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility and the state licensure agency." 23. Review of the provider's reviewed December 2021 Abuse Prohibition policy revealed that the facility was "To utilize the abuse prohibition investigative protocol to be in compliance with federal regulations." "Documentation is required for all suspicious injuries, bruises, skin tears, fractures, and injuries of unknown origin." "The primary RN or DON will complete necessary documentation surrounding the injury using the Injury Assessment form." "Abuse, involuntary seclusion, and misappropriation of property will be reported to the primary registered nurse (RN) and then to the director of nursing (DON) or social worker who will be responsible for initial investigation of the incident." "Document the investigation by using the Grievance Complaint Investigation form, and place it with the investigation report."	F0609		

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F0609 SS = D	Continued from page 117 "The facility is to notify the Department of Health within 24 hours of any alleged abuse, neglect, or misappropriation of a resident's property." "The report may be faxed or called in by the administrator, DON, social worker, or other designated person." "The administrator, DON, social worker, or other designated person has 5 working days to complete the investigation unless a verbal approval for an extension is obtained from the DOH." "A copy of the completed investigation will be recorded on the Resident Abuse Investigation form and will be provided to the administrator, resident, or resident representative within 5 working days of the reported incident." "The administrator, DON, social worker, or other designated person will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency within 5 working days of the reported incident, notify the local or state ombudsman of the occurrence, investigation, and corrective action, and invite them to participate in the investigation process." "Corrective actions to be implemented and monitored by the administrator, DON, social worker, or other designated person." 24. Review of the undated admission packet revealed that "The facility will notify the resident or representative when an accident or injury occurs." "A resident, his or her representative, family member, visitor, or advocate may file a verbal or written grievance or complaint concerning treatment, abuse, neglect, harassment, or medical care." "Complaints of abuse, harassment, or mistreatment will be immediately investigated and you will receive a written and/or verbal report of the findings, and/or corrective actions taken within five working days of filing the report." 25. Review of the provider's revised January 2020 Accidents and Incidents policy revealed ..."all accidents or incidents occurring on our premises must be reported to the administrator." "Regardless of how minor an accident or incident may be, it must be reported to the department supervisor and an Accident or Incident Report Form must be completed on the shift that the accident or incident occurred." "The Investigation Report Form must be submitted			F0609			

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F0609 SS = D	Continued from page 118 to the Director of Nursing Services no later than twelve (12) hours after the occurrence of the accident or incident." "Submit the original copy of the Investigation Report and the Accident and Incident Report to the Administrator no later than 24 hours after the occurrence of the accident or incident." The policy did not address reporting timelines for reporting incidents, accidents, or suspicion or allegations of resident abuse or neglect to the SD DOH.	F0609		
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F0655	The Baseline Care Plan policy was reviewed and revised to ensure compliance with regulatory requirements, including development and implementation within required time frames and inclusion of resident-centered goals and interventions. All licensed nurses and applicable interdisciplinary team members will receive education on the updated Baseline Care Plan policy and procedure. Education will be completed during a mandatory staff meeting and finalized by July 9, 2026. Any staff unable to attend will receive 1:1 education prior to their next scheduled shift. At the time of this Plan of Correction, the facility has not had a new admission to audit for Baseline Care Plan compliance. Upon the next admission, an audit will be completed to ensure the Baseline Care Plan is initiated, completed within 48 hours, reviewed, and offered with the resident and/or family/POA. Findings will be reviewed through the monthly QAPI process for review and recommendation. The Director of Nursing (DON) and/or Assistant Director of Nursing (ADON) will conduct audits of all new admissions for Baseline Care Plan compliance weekly for four (4) weeks, then monthly for three (3) months. Any identified concerns will be addressed immediately with staff re-education and corrective action as indicated.	07/09/2026

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F0655 SS = D	Continued from page 119 (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the resident's baseline care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was completed, was reviewed with, and a copy was offered to the resident or the resident's representative within 48 hours of the resident's admission to the facility for three of four sampled newly admitted residents (3, 6, and 14). Findings include: 1. Review of resident 14's electronic medical record (EMR) revealed he was admitted to the facility on 2/11/26. His 5/14/26 Brief Interview of Mental Status (BIMS) assessment score was 13, which indicated his cognition was intact. His diagnoses included hemiparesis (paralysis on one side of the body following cerebral infarction (stroke) affecting his right dominant side, adult failure to thrive, repeated falls, hypertension (high blood pressure), chronic ischemic heart disease (a long-term condition where the heart muscle receives insufficient blood and oxygen), and vitamin D and B deficiencies. His baseline care plan assessment was initiated on 2/19/26, but was not completed. There was no documentation that indicated his diagnoses, his diet, or that the social services section had been completed. There was no documentation that a copy of the baseline care plan was offered to or reviewed	F0655		

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F0655 SS = D	Continued from page 120 with the resident or his representative within 48 hours of his admission to the facility. 2. Review of resident 6's EMR revealed he was admitted to the facility on 11/17/25. His 5/14/26 BIMS assessment score was 5, which indicated his cognition was severely impaired. His diagnoses included type 2 diabetes mellitus (a chronic metabolic condition characterized by high blood sugar levels), peripheral vascular disease (a circulation disorder characterized by the narrowing, blockage, or spasms of blood vessels outside of the heart and brain), chronic kidney disease (loss of the kidneys' ability to filter waste and excess fluid from the blood), cerebral infarction (stroke), repeated falls, weakness, and tremor (involuntary, rhythmic shaking or trembling movement). His baseline care plan assessment was completed on 11/17/26. There was no documentation that indicated his diagnoses, his bed-to-chair transfer status, or that the social services section had been completed. There was no documentation that a copy of the baseline care plan was offered to or reviewed with the resident or his representative within 48 hours of his admission to the facility. 3. Review of resident 5's EMR revealed she was admitted on 3/11/25. Her 5/19/26 BIMS assessment score was 13, which indicated her cognition was intact. Her diagnosis included diverticulosis (a painful digestive condition that occurs when small, bulging pouches in the lining of your colon (called diverticula) become inflamed or infected), atrial fibrillation (a type of irregular heart beat), type 2 diabetes mellitus (a chronic metabolic condition characterized by high blood sugar levels), hypertension, low back pain, depressive episodes (a distinct period of at least two weeks characterized by a persistent low mood, sadness, or a complete loss of interest in activities), presence of cardiac pacemaker (a small, battery-operated medical device implanted in the chest or abdomen), Alzheimer's Disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills), and dementia (a group of symptoms that negatively impact memory, thinking, and social abilities). Her baseline care plan assessment was completed on 3/11/25. There was no documentation that indicated her diagnoses, her code status, or that the social services section had been completed. There was no documentation that a copy of the baseline care plan was offered to or reviewed with the			F0655			

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F0655 SS = D	Continued from page 121 resident or his representative within 48 hours of his admission to the facility. 4. Interview on 6/1/26 at 12:17 p.m. with director of nursing (DON) B regarding baseline care plans revealed she expected the baseline care plan to be completed as soon as possible, within 48 hours after a resident admitted to the facility. She was unsure if the social services department contributed to the baseline care plan. The resident or the resident's representative was not offered or provided a copy of the baseline care plan. She was unaware that the regulation required the baseline care plan to be reviewed with the resident or their representative, and a copy was to be provided. 5. Review of the provider's revised February 2020 Care Plans: Preliminary, Comprehensive and Reviews policy revealed the provider "assures each resident has a preliminary care plan developed at admission to address immediate care needs." " Preliminary care plans are used until the Comprehensive Care plan has been completed and addressed the following areas of care for the resident: Problems..., Strengths..., Short/Long-ter Goals..., Approach..., Time Frame..."			F0655			

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/26/26 through 5/28/26 and 6/1/26 through 6/2/26. Winner Regional Healthcare Center was found not in compliance with the following requirements: S206, S210, S236, and S301.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel	S 206	The policy titled "Required Annual Training of Long-Term Care Healthcare Workers" has been updated to include mandatory education on Abuse and Neglect, as well as Advanced Directives. In addition, a new policy titled "Abuse and Incident Investigation Policy and Form" has been developed to clearly outline staff responsibilities for reporting incidents. All staff are required to complete the MedTrainer module "Reporting Neglect and Abuse in Adults" on an annual basis. Additional education will be provided on reportable diseases, and informational posters identifying reportable diseases are displayed throughout the facility to reinforce this requirement. Employee training status is as follows: - Employee O has completed the required training. - Employee R is no longer employed at WRH. - Employee Y will complete training 7/9/26 - Employee F has completed the required training. - Employee Q will complete training by 7/9/2026. - Employee U is no longer employed at WRH.	7/9/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

CEO

(X6) DATE

7.16.26

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S 206	Continued From page 1 education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review, interview, and policy review, the provider failed to ensure that three of three newly hired employees reviewed (O, R, and Y) completed the required orientation training within 30 days of their hire date and three of three employees reviewed (F, Q, and U) completed the required annual training. Findings include: 1. Review of certified nursing assistant (CAN) O's employee record revealed she was hired on 2/5/26. She did not complete the required orientation training within 30 days of her hire date regarding the topics of mandatory reporting of incidents and diseases, and advanced directives. 2. Review of contracted travel licensed practical nurse (LPN) R's employee record revealed she was hired on 4/27/26. She did not complete the required orientation training within 30 days of her hire date regarding the topics of fire prevention and response, emergency preparedness and procedures, infection prevention and control, accident prevention and safety procedures, proper use of restraints, resident rights, confidentiality of resident information, mandatory reporting of incidents and diseases, dining assistance nutritional risks and hydration, abuse and neglect, and advanced directives. 3. Review of housekeeping aide Y's employee record revealed she was hired on 4/7/26. She did not complete the required orientation training within 30 days of her hire date regarding the	S 206	All other employees not listed above will complete the required education by 7/9/2026. Human Resources will conduct ongoing audits to ensure compliance with training requirements for all new employees at Winner Long Term Care. Audit findings will be reviewed with the Director of Nursing or designee and will be monitored monthly times 6 months and taken to QAPI monthly for review and recommendations.	

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S 206	Continued From page 2 topics of mandatory reporting of incidents and diseases, and advanced directives. 4. Review of social service designee (SSD) F's employee record revealed she was hired on 6/6/19. She did not complete the required annual training regarding the topics of infection prevention and control, proper restraint use, mandatory reporting of incidents and diseases, dining assistance nutritional risk and hydration, and advanced directives. 5. Review of registered nurse (RN) Q's employee record revealed she was hired on 6/6/19. She did not complete the required annual training regarding the topics of mandatory reporting of incidents and diseases, and advanced directives. 6. Review of contracted travel CNA U's employee record revealed she was hired on 3/7/23. She did not complete the required annual training regarding the topics of proper restraint use, and mandatory reporting of incidents and diseases. 7. Interview and review of the required employee training records on 5/27/26 at 5:05 p.m. with human resources director J revealed that SSD F had not completed the required annual training in the topics of infection prevention and control, proper restraint use, and dining assistance nutritional risk and hydration in the past year. Human resources director J was not aware that the mandatory reporting of diseases, and advanced directives were required training topics, so no employees were assigned mandatory reporting of incidents and diseases or advanced directives as part of the training that was required to be completed within 30 days of their hire date and annually.	S 206		

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S 206	Continued From page 3 Human resources director J was responsible for assigning the required training for each employee to complete. She and the employee's supervisor were responsible for ensuring each employee completed the required education within 30 days of their hire date and annually. 8. Interview on 6/1/26 at 11:56 a.m. with director of nursing (DON) B revealed she was responsible for assigning the required training to all contracted travel employees. Human resources director J was responsible for assigning the required training to the provider's employees. She expected the employees to complete the required training within two weeks of their hire date and annually. 9. Interview on 6/2/26 at 12:31 p.m. with chief executive officer (CEO) A revealed he acknowledged that there was required education that was not completed by employees F, O, Q, U, R, and Y. 10. Review of the provider's August 2018 Required Annual Training of Long-Term Care Healthcare Workers policy revealed that employee training was to be completed in accordance with state and federal regulation. The provider "shall maintain a formal orientation program and an ongoing education program for all personnel through the [redacted program name]." "Orientation and ongoing education shall cover the following required subjects annually: a. Fire prevention and response ... b. Emergency procedures and preparedness; c. Infection control and prevention; d. Accident prevention and safety procedures; e. Resident rights; f. Confidentiality of patient information;	S 206			

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S 206	Continued From page 4 g. Incident and diseases subject to mandatory reporting and reporting mechanisms h. Abuse prevention and reporting of abuse or residents and between residents.	S 206		
S 210	44:73:04:06 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. Before assignment to duties or within fourteen days after employment, a licensed health professional must evaluate all personnel to ensure no personnel is infected with any reportable communicable disease that poses a threat to others. The evaluation must include an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease that may endanger the health of residents, and fellow personnel may not return to duty until the personnel is determined by a physician, physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review, interview, and policy review, the provider failed to ensure an employee health evaluation was reviewed by a licensed healthcare professional to ensure the employee was not infected with any reportable communicable disease that would pose a threat to others within fourteen days of hire for two of three employees reviewed (O and Y).	S 210	New Employee health assessments will be signed off by employee health nurse within 21 days of hire. Audits will be discussed with QAPI team once a month during scheduled QAPI meeting. CNA - O-health assessment was reviewed and signed off by employee health nurse. Housekeeping Aide Y-health assessment was reviewed and signed off by employee health nurse. HR emailed and informed to update Employee Health Program policy to state all employee health files will be signed by a licensed healthcare professional within 21 days of hire and completed on 06/25/2026. This must be completed by day 21 or the employee will not be allowed to return to work until the test has been completed. All health assessment forms on all employees was completed on 06/03/2026.	07/09/2026

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S 210	Continued From page 5 Findings include: 1. Review of certified nursing assistant (CNA) O's employee record revealed she was hired on 2/15/26. Her 2/16/26 health evaluation was not signed to indicate the health evaluation was reviewed by a licensed healthcare professional. 2. Review of housekeeping aide Y's employee record revealed she was hired on 4/7/26. Her 4/7/26 health evaluation was not signed to indicate the health evaluation was reviewed by a licensed healthcare professional. 3. Interview and review of CNA O's and housekeeping aide Y's employee health evaluations on 6/2/26 at 8:51 a.m. with infection preventionist (IP) D revealed human resources director J was responsible for ensuring each employee completed their employee health evaluation upon hire. Human resources director J then gave IP D the employee health evaluation. IP D reviewed the employee health evaluations to be sure they were completed by the employee and then filed them in her office. IP D was not aware that the employee health evaluations were to be reviewed by a licensed healthcare professional to ensure the staff member was not infected with a reportable communicable disease. IP D acknowledged CNA O's and housekeeping aide Y's employee health evaluations were not signed by a licensed healthcare professional. 4. Review of the provider's April 2020 Employee Health Program policy revealed the "Employee Health Service (EHS) will provide a health assessment of all job applicants prior to their beginning employment date." "Applicants may be	S 210			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 210	Continued From page 6 referred for further medical evaluation as deemed appropriate by the Employee Health nurse." "Applicants will complete an Employee Health Assessment questionnaire which includes; history of medical condition; account of prior injury; treatment or disability rating; need for work restrictions or other worksite accommodations; and documentation of communicable illness/immunization history." The provider's April 2020 Employee Health Program policy did not address that the employee health evaluation needed to be reviewed and signed by a licensed healthcare professional to ensure the employee was not infected with any reportable communicable diseases.	S 210		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare personnel or residents are as follows: (1) Each new healthcare personnel or resident shall receive an initial individual TB risk assessment and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. The qualified personnel must record the assessment and the test in the employee's record or the resident's medical record. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment is considered a two-step test. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel	S 236	All current employees were reviewed on 06/03/2026. Four employees were noted be out of compliance. This will be corrected by 07/09/2026. New employee TB screening will be evaluated and completed within 21 of hire. Audits will be discussed with QAPI team once a month for six months during the scheduled QAPI meeting for review and recommendations. Employee health TB screening policy was updated to reflect that all newly hired employees will have TB testing done within 21 days of hire. Completed 06/03/2026. Housekeeping Aide Y-TB testing was completed within 21 days of hire and filed in employee health file. Completed on 06/03/2026.	07/09/2026

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S 236	Continued From page 7 or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin testing having been completed within the prior twelve months. Skin testing or a TB blood assay test is not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any new healthcare personnel or resident who has a newly recognized positive reaction to the skin test or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure four of five sampled residents (14, 24, 27, and 32) received a two-step tuberculin (TB) skin test or a QuantiFERON Gold lab test within twenty-one days of their admission to the facility and two of five employees reviewed (dietary manager G and housekeeping aide Y) received a two-step TB skin test or a QuantiFERON Gold lab test within twenty-one days of their hire date. Findings include: 1. Review of resident 14's electronic medical record (EMR) revealed he admitted to the facility 2/11/26. A QuantiFERON Gold lab test was completed on 4/3/26, 51 days after he admitted to the facility. 2. Review of resident 27's EMR revealed she	S 236	Implemented new procedure to ensure TB testing is completed within 21 days of hire. o 1st-Contact will be made by employee health nurse to new employee and their director that TB testing needs to be done ASAP. o 2nd-Within 7 business days if employee health nurse does not have results of employee TB testing. CEO will be contacted. o 3rd- CEO will then follow up with new employee and director to ensure testing is completed within 21 days of hire.	

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S 236	Continued From page 8 admitted to the facility on 3/4/26. A QuantiFERON Gold lab test was completed on 4/3/26, 30 days after she admitted to the facility. 3. Review of resident 24's EMR revealed he admitted to the facility on 3/5/26. A QuantiFERON Gold lab test was completed on 4/3/26, 29 days after he admitted to the facility. 4. Review of resident 32's EMR revealed she was admitted to the facility on 4/16/26. There was no documentation that a QuantiFERON Gold lab test, or TB skin test completed for resident 32. 5. Review of dietary manager G's employee record revealed she was hired on 7/28/25. A QuantiFERON Gold lab test was completed on 9/5/25, 39 days after she was hired. 6. Review of housekeeping aide Y's employee record revealed she was hired on 4/7/26. There was no documentation that a QuantiFERON Gold lab test, or a TB skin test had been completed for housekeeping aide Y. 7. Interview and record review on 6/1/26 at 11:56 a.m. with director of nursing (DON) B revealed she was responsible to ensure the residents had a two-step TB test or a QuantiFERON Gold lab test completed upon the resident's admission to the facility. Residents who did not have a two-step TB skin test completed within a year before they were admitted to the facility or a QuantiFERON Gold lab test were to have a QuantiFERON Gold lab test completed when they admitted to the facility. She acknowledged that resident 32 did not have a two-step TB skin test or a QuantiFERON Gold lab test complete because the resident refused	S 236			

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S 236	Continued From page 9 the testing and DON B was waiting for the resident's son to visit with the resident to see if she would allow the staff to draw her blood for the QuantiFERON Gold lab test to be completed. DON B acknowledged that residents 14, 24, and 27 did not have the QuantiFERON Gold lab test completed within 21 days of their admissions to the facility. She was not aware that the two-step TB skin test or the QuantiFERON Gold lab test needed to be completed within 21 days of the residents' admission to the facility. 8. Interview and employee record review on 6/2/26 at 8:51 a.m. with infection preventionist (IP) D revealed she was responsible for ensuring the employees had a two-step TB test or a QuantiFERON Gold lab test completed when they were hired. If the employee did not have documentation that a two-step TB skin test or a QuantiFERON Gold lab test was completed within a year prior to their hire date, the employee was to complete a QuantiFERON Gold lab test. She would instruct the employee on how and where the lab test was to be completed. Her goal was that all employees complete the QuantiFERON Gold lab test within 30 days of hire. If the employee did not complete the lab test, she would remind the them and their supervisor that it needed to be completed. Then that employee's supervisor was responsible for ensuring the QuantiFERON Gold lab test was completed. IP D was not aware that a two-step TB skin test or a QuantiFERON Gold lab test was required to be completed within 21 days of an employee's hire date. 9. Review of the provider's March 2023 TB: Exposure Control Plan and Management of	S 236			

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S 236	Continued From page 10 Healthcare Workers policy revealed, "At the time of employment all HCWs [healthcare workers] including those with a history of vaccination with BCG will receive a TST [TB skin test]." "On the initial test, two-step testing will be performed. Documentation of a TST or blood assay for TB in the previous year may serve as the first step of the two-step test." 10. Review of the provider's 8/5/25 Tuberculosis Screening policy revealed "Tuberculosis Requirement: Must submit documentation of tuberculosis test performed within 30 days of employment. The acceptable tuberculosis test includes QuantiFERON, or 2 step TB skin test."	S 236		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by:	S 301	All dietary training is completed monthly through mandatory attendance at in-service meetings led by the Dietitian and Dietary Director. Each session includes education on topics required by state regulations. Employees who are unable to attend the scheduled training are required, within seven (7) days, to complete the assigned material. This includes reviewing all required handouts, watching any assigned videos, and discussing the monthly topic with the Dietary Director. The employee must sign a form verifying completion of the training. This documentation will be maintained in the In-Service Manual for review.	

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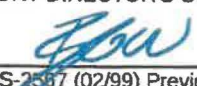
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S 301	Continued From page 11 Based on employee record review, interview, and policy review, the provider failed to ensure one of one newly hired dietary employee reviewed (dietary manager G) completed the required dietary orientation training within 30 days of her hire date and one of one dietary employee reviewed (dietary assistant P) completed annual required dietary training. Findings include: 1. Review of dietary manager G's employee file revealed she was hired on 7/28/25. There was no documentation that she completed training related to food safety, handwashing, food handling and preparation, the serving and distribution of food, leftovers, time and temperature controls, nutrition and hydration, and sanitation within 30 days of her hire date. 2. Review of dietary assistant P's employee file revealed he was hired on 2/6/24. There was no documentation that he completed annual required training related to food safety, food handling and preparation, foodborne illnesses, the serving and distribution of food, left overs, the time and temperature controls, and sanitation. 3. Interview on 5/27/26 at 4:48 p.m. with human resources director J revealed that all dietary education was completed at scheduled in-person dietary staff meetings by dietary manager G and registered dietician V. Dietary manager G did not complete the required dietary training within 30 days of her hire date because the training courses were divided into monthly assignments to be completed throughout the year. Dietary assistant P worked in the dietary department as needed and did not attend the scheduled in-person dietary training.	S 301	The Dietary Director and Dietitian will conduct audits of completed training monthly for three (3) months, and quarterly thereafter. This process will continue indefinitely to ensure ongoing compliance. A formal policy will be completed to clearly define the mandatory nature of dietary training, outline expectations for attendance, and specify the process and consequences for missed in-service meetings. Employee G is enrolled in class and will complete. Employee P will have all education prior to 7/9/26.. All Dietary staff were reviewed and no additional gaps noted.	7/9/26

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S 301	Continued From page 12 4. Review of the provider's August 2018 Required Annual Training of Long-Term Care Healthcare Workers policy revealed that employee training was to be completed in accordance with state and federal regulation. The provider "shall maintain a formal orientation program and an ongoing education program for all personnel through the [redacted program name]." "The Education Coordinator will pull required learning modules from [redacted program name] to assure healthcare worker access to [the] required modules annually."	S 301	Employee P will have all prior education completed by 07/09/2026.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/27/2026
NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST , WINNER, South Dakota, 57580	
(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 5/27/26. Winner Regional Healthcare Center was found in compliance.	E0000		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 7-5-26
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/27/2026
NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST , WINNER, South Dakota, 57580	
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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 5/27/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Winner Regional Healthcare Center was found in compliance.	K0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 30 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

CEO

3 July 26