

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435068	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER AVANTARA WATERTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 415 FOURTH AVE NE , WATERTOWN, South Dakota, 57201	
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F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/16/26 through 6/17/26. Areas surveyed included potential resident neglect and a potential violation of a resident's rights related to a resident who was left unattended in the dining room for several hours, residents potentially not receiving ordered medications and wound dressing changes, the quality of care related to overnight incontinence care provided, and notification to a resident's representative when a resident was transferred to the hospital. Avantara Watertown was found not in compliance with the following requirement: F684.	F0000		
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, observation, record review, and policy review, the provider failed to ensure residents received care in accordance with their plan of care by two of two certified nursing assistants (CNAs) (N and Q) who did not change six of eight sampled residents' (1, 2, 3, 4, 5, and 6) incontinence (involuntary urine or bowel leakage) products during the night shift and did not reposition one of one sampled resident (4) who was found sideways in bed with urine-stained bedsheets, and by one of one contracted travel CNA (Z) who left one of one sampled resident (5) alone in the dining room for over three hours.	F0684	1. Residents #1, #2, #3, #4, #5, and #6 were provided cares, skin assessments and bladder assessments completed on 6/16/2026 by the nurse managers. Care plans for residents who were affected by quality-of-care concerns were updated based on bladder assessments. All residents with incidents regarding quality of care were further investigated and responsible party and providers were notified on 6/16/2026. Resident #4's bed was assessed by nursing leadership for optimal positioning to facilitate repositioning. The mattress was evaluated for effectiveness related to incontinent episodes and replaced as indicated on 7/13/2026. Resident #5's care plan and dining supervision interventions were reviewed to ensure prompt assistance from the dining room following meals. Staff were re-educated on timely return of residents requiring post-meal assistance. The Nursing Standards of Care and Skin and Pressure Injury Prevention Program were reviewed. The facility's toileting and bowel and bladder protocols were reviewed and reinforced with staff. No policy revisions were required. All residents have the potential to be affected by deficient practice. 2. DON or designee will complete education with all nursing staff, who provide incontinence care, education to include incontinence care, repositioning care and assisting residents from the dining room after meals. DON or designee will complete education with all staff who assist with meals and those who participate in the manager on duty schedule, on ensuring that all	8/1/2026

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE LYNNA M. SPEIER	TITLE LNHA	(X6) DATE 7/13/2026
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F0684 SS = E	Continued from page 1 Findings include: 1. Review of the provider's 6/16/26 at 1:00 p.m. SD DOH FRI revealed CNA M reported to the director of nursing (DON) B and regional nurse consultant (RNC), unidentified in report, that at the start of the day shift (6:30 a.m.), she found several residents who were "heavily incontinent". She described resident 1 as being "soaked through the incontinent brief and was incontinent of bowel." Resident 3 was "wet/soaked from the shoulders down." Resident 2 was "soaked with urine." Resident 4 was "positioned sideways in bed and, upon repositioning, a urine stain was observed in the middle of the bed." Resident 5 "stated that a CNA had placed a wet pillow underneath his side." CNA M reported that CNA R found resident 6 "soaked from head to toe." The report indicated that "residents were provided appropriate hygiene care, incontinent care, repositioning, and linen changes. Skin assessments are underway." It indicated that the physician and families were being notified, the care plans were being reviewed and updated as needed, and staff education would be completed. The investigation was ongoing. 2. Interview on 6/16/26 at 5:52 a.m. with CNA Q, conducted prior to review of the 6/16/26 FRI report, revealed that she was a new CNA and was still training on the night shift. She stated that standard practice was to complete resident rounds, which included repositioning residents and either helping them use the toilet or changing their incontinence briefs, every two to three hours. 3. Observation and interview on 6/16/26 at 6:00 a.m. of CNA M providing care to resident 3 in her room revealed that resident 3 was lying on her back, CNA M turned resident 3 onto her side, and resident 3's incontinence brief, the pad under her, her night gown, and the sheet under her were soiled. CNA M stated, "She wasn't changed at all last night." Resident 3's room smelled of urine. CNA M stated that sometimes in the mornings when she came to work, residents were found lying in their beds soiled, and it depended on which CNA worked the night shift. Resident 3 could not tell anyone when she needed to be changed. When CNA M found residents incontinent in bed, she would tell the nurse, and the nurse would report it to DON B.			F0684	are removed from the dining room after meals. Education will occur no later than 8/1/2026 and those not present will be educated prior to their next scheduled shift. 3. DON or designee will audit 5 random residents weekly for four weeks, then monthly two additional months to ensure that they are being repositioned and that incontinence care is being performed to include dry and clean linen. Administrator or designee will audit 5 random meals across all shifts weekly for four weeks, then monthly two additional months to ensure that all residents are removed from the dining room after meals. Administrator or designee will present audit findings monthly in QAPI meeting for progress review and further recommendations.		

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F0684 SS = E	Continued from page 2 Review of resident 3's EMR revealed she admitted to the facility on 3/17/25. Her 3/22/26 Brief Interview for Mental Status (BIMS) assessment score was 3, which indicated her cognition was severely impaired. She had a diagnosis of Alzheimer's Disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), pain, difficulty in walking, and weakness. Her 6/9/26 Braden Scale (a tool used to assess the risk of developing pressure ulcers) assessment score was 12, which indicated that she was at high risk for developing a pressure sore (skin/and or underlying tissue injury from prolonged pressure), and that her skin was often moist. Resident 3's 4/11/26 care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) indicated she was dependent on the staff for assistance with completing her activities of daily living (ADLs), which included personal hygiene care. Her incontinence brief was to be checked and changed every "few hours." The CNA task documentation in the computer system indicated resident 3 was incontinent of urine on 6/15/26 at 9:53 p.m., 6/16/26 at 12 a.m., and 2 a.m. She was dry at 4 a.m. and incontinent of urine at 6 a.m. The 6/16/26 night shift CNA sheet (a document that identifies residents' care needs and interventions) indicated resident 3 required staff to check and change her incontinence brief every two hours from 12 a.m. until 4 a.m. 4. Observation on 6/16/26 at 7:10 a.m. of CNA M providing care to resident 1 in her room revealed that resident 1's incontinence brief was soiled. CNA M said the pad under her was also soiled. CNA M assisted resident 1 onto the bedpan (a shallow tray used as a toilet by people who are confined to bed or unable to walk to the bathroom), and she had a continent void. Resident 1's had redness to her groin, maceration (damage to skin from being wet for too long) to her left and right inner buttocks, and superficial open areas across her sacrum (the base of the spine, sitting directly between the hip bones). Review of resident 1's electronic medical record	F0684			

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F0684 SS = E	Continued from page 3 (EMR) revealed she admitted to the facility on 12/16/21. Her 3/17/26 BIMS assessment score was 15, which indicated her cognition was intact. She had a diagnosis of generalized anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), non-surgical impingement syndrome (a condition where tissues like tendons and cushioning sacs get painfully pinched inside a joint every time the arm is lifted) of both shoulders, lumbar radiculopathy (pinched or irritated nerve in the low back), and chronic pain. Her 5/24/26 Braden Scale assessment score was 17, which indicated she was at high risk for developing a pressure ulcer, and that her skin was occasionally moist. Resident 1's 6/1/26 care plan indicated she was dependent on the staff for toilet hygiene, dressing her lower body, and transfers. She required substantial assistance to move in bed and to dress her upper body. She required the use of the sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) for all transfers. She used the bedpan at night, and the staff was to change her incontinent brief as needed. The CNA task documentation indicated resident 1 was continent of urine on 6/15/26 at 9:40 p.m. and incontinent of urine on 6/16/26 at 6:29 a.m. She was not scheduled in the tasks to be checked and changed at 4 a.m. The 6/16/26 night shift CNA sheets indicated staff was to assist resident 1 with the bedpan when she requested. It indicated she "usually rings" at midnight and that she required to be "checked and changed" at 4 a.m. Resident 1's 6/13/26 Skin Evaluation assessment indicated that she had redness to her groin, and she had maceration to her inner buttocks. Her 6/16/26 Skin Evaluation assessment indicated that she did not have any changes since her previous skin assessment. Resident 1's 6/17/26 Skin Evaluation assessment indicated she had maceration to her left and right buttocks and to her sacrum. 5. Interview on 6/16/26 at 7:30 a.m. with resident 1 revealed that staff usually help her to the bathroom during the night, but they did not last night. She did not let the staff know she was wet because she did not know she had to urinate. 6. Interview on 6/16/26 at 7:32 a.m. with CNA M revealed that resident 1 usually rang her call light	F0684			

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F0684 SS = E	Continued from page 4 during the day shift when she needed to use the bathroom. 7. Interview on 6/17/26 at 6:30 a.m. with registered nurse (RN) K revealed she worked on the night shift. She thought CNA Q "was doing well." RN K monitored that residents were being checked and changed at night by listening to the CNA discussions that came across the radios, and she offered assistance to the CNAs. She was not sure if resident 1 used her call light at night to alert staff when she needed to use the bathroom. 8. Interview and EMR review on 6/17/26 at 10:26 a.m. with licensed practical nurse (LPN) V revealed that resident 1 had superficial open areas to her sacrum and not just her inner buttocks. She would not state if it was a change from resident 1's previous skin assessment, which indicated the maceration was to her inner buttocks, because she had not seen resident 1's skin before that day. 9. Interview on 6/17/26 at 10:35 a.m. with DON B revealed that she had not looked at resident 1's wounds on wound rounds. 10. Observation on 6/17/26 at 10:48 a.m. revealed that DON B completed a wound assessment on resident 1 and measured her wounds. DON B stated that she would now monitor resident 1's skin during wound rounds so she could monitor it weekly and notify the physician to receive different treatment orders. 11. Interview on 6/17/26 at 2:18 p.m. with DON B revealed that resident 1 had experienced a recent decline, and the staff were to check in with resident 1 every two hours to offer her bathroom assistance and to see if she was incontinent. She verified that with resident 1's decline, the staff should have been proactive in updating her plan of care. 12. Interview on 6/17/26 at 3:20 p.m. with DON B and RNC Y revealed that they could not verify that resident 1's skin was worse than the previously documented skin assessments that indicated that resident 1 had maceration to her inner left and right buttocks, and now had open areas on her sacrum since they had not seen her wound before and without a diagram of where the maceration areas were previously at.	F0684			

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F0684 SS = E	Continued from page 5 13. Observation on 6/16/26 at 7:35 a.m. of CNA M providing care to resident 2 in her room revealed that resident 2 was lying on her back. CNA M turned resident 2 onto her side, and her incontinence brief was soiled. Review of resident 2's EMR revealed she admitted to the facility on 7/11/25. Her 4/18/26 BIMS assessment score was 6, which indicated her cognition was severely impaired. She had a diagnosis of need for assistance with personal care, cognitive communication deficit, muscle wasting (muscles shrinking, thinning, and losing strength), and abnormalities of gait (walking) and mobility. Her 6/12/26 Braden Scale assessment score was 16, which indicated she was at high risk for developing a pressure ulcer. It indicated her skin was rarely moist. Resident 2's 6/8/26 care plan indicated she was dependent on the staff for toileting hygiene, personal hygiene, and dressing her lower body. She required a substantial amount of staff assistance for dressing her upper body, repositioning in bed, and transferring. The staff were to offer and assist her as needed with using the bathroom. The staff were to reposition her every two to three hours. Resident 2's CNA task documentation indicated she did not indicate that the CNAs were to check and change her every two hours. The CNAs documented that she was incontinent of urine on 6/15/26 at 9:30 p.m. and on 6/16/26 at 6:29 a.m. There was no documentation to support if she had been checked or changed between 9:30 p.m. and 6:29 a.m. The 6/16/26 night shift CNA sheets indicated that resident 2 was to be "checked and changed" at 12 a.m., 2 a.m., and 4 a.m. 14. Interview and EMR review on 6/17/26 at 2:18 p.m. with DON B revealed that resident 2's CNA task documentation should have indicated that she needed to be checked and changed every two hours. DON B was responsible for adding that to the resident's EMR. 15. Interview and observation on 6/17/26 at 7:34	F0684			

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F0684 SS = E	Continued from page 6 a.m. with housekeeper U revealed that resident 4 was sleeping in his bed. His room did not smell of urine. Housekeeper U said she cleaned resident 4's bathroom several times each day because he often missed the toilet while urinating throughout the night. Review of resident 4's EMR revealed that he admitted to the facility on 3/28/22. His 4/10/26 BIMS assessment score was 11, which indicated his cognition was moderately impaired. He had a diagnosis of chronic kidney disease and other specified disorders of the bladder, left-sided hemiparesis (muscular weakness) and hemiplegia (paralysis on one side of the body), contracture (tightened or shortened connective tissue, tendons or skin) of the left hand, muscle wasting and atrophy (shrinking or progressive decline) due to a cerebrovascular accident (when blood flow to the brain is interrupted, commonly referred to as a stroke), and a history of bladder retention and urinary tract infections (UTIs). Resident 4's 4/10/26 Minimum Data Set (MDS) assessment revealed that he was occasionally incontinent of bowel and bladder. His 6/16/26 care plan indicated that he wished to maintain independence with toileting and incontinence care and frequently declined assistance. He was to be checked for incontinence and offered assistance or supervised with changing his brief every two to three hours and as needed. His 6/7/26 Braden Scale assessment score was 17, which indicated that he was at high risk for developing a pressure sore and that his skin was often very moist. The CNA task documentation indicated resident 4 was incontinent of urine every day except on 6/11/26. He refused staff assistance on 6/15/26 at 9:57 p.m. The 6/16/26 night shift CNA sheet indicated resident 4 was incontinent of bowel and bladder, wore incontinence briefs, needed assistance with toileting, and should be checked on during rounds. The CNA task documentation from 6/4/26 through 6/16/26 indicated he was checked twice each night on 6/6/26, 6/7/26, and 6/13/26, and three times each of the other nights. 16. Observation and interview on 6/17/26 at 7:29 a.m. with CNA P revealed that resident 5 was incontinent and changed at 6:30 a.m. and wanted to sleep for another hour. At 7:30 a.m. he was incontinent but did not need his bedding changed.	F0684		

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F0684 SS = E	Continued from page 7 Review of resident 5's electronic medical record (EMR) revealed that he admitted to the facility on 10/8/24. His 4/17/26 BIMS assessment score was 11, which indicated his cognition was moderately impaired. He had a diagnosis of weakness and difficulty walking. Resident 5's 4/17/26 MDS assessment revealed that he was incontinent of both bowel and bladder. His 6/2/26 care plan indicated that he required daily assistance with toileting, hygiene, bed mobility and transfers, and that he was to be repositioned every two hours. His 6/16/26 Braden Scale assessment score was 13, which indicated that he was at high risk for developing a pressure sore and that his skin was often very moist. The CNA task documentation spanning from 6/4/26 to 6/16/26 indicated he was incontinent of urine three to four times each day. The 6/16/26 night shift CNA sheets indicated resident 5 was to have "check and change" rounds completed at 12 a.m., 2 a.m., and 4 a.m. Night shift documentation for 6/15/26 revealed that he was checked once and was continent at 4:20 a.m. Night shift documentation on 6/16/26 revealed he was checked once and was incontinent at 3:11 a.m. 17. Interview on 6/17/26 at 1:28 p.m. with CNA N revealed that night shift tasks included stocking medical supplies, emptying garbage cans, answering resident call lights, and completing resident rounds every two hours. She said some residents consistently need more help than others, and the staff have asked DON B and administrator A to hire a third CNA for the night shift. She recalled that on the night of 6/15/26, leading into the morning of 6/16/26, there were a lot of resident call lights, and resident 5 had several incontinent episodes that required linen changes. CNA N stated she does not always document every time she finds a resident incontinent. 18. Interview on 6/17/26 at 4:41 p.m. with CNA R revealed that while helping resident 5 get dressed on the morning of 6/16/26, she found a pillow tucked under his side that was wet, "I believe with urine." Residents 5 and 6 frequently wake up incontinent and need their bedding changed. "I've tried to pass that on to the evening and night shifts, that they needed to be changed every two hours." 19. Observation and interview on 6/17/26 at 5:45 a.m. with RN W revealed resident 6 lying in urine-soaked sheets and pajamas. Resident 6's	F0684			

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F0684 SS = E	Continued from page 8 room smelled of urine. RN W said she had changed resident 6's incontinence brief two hours ago. She stated that after learning that six residents were found heavily incontinent on 6/16/26, nurses were directed to assist CNAs with rounds. RN W normally worked the day shift but had worked the previous night shift to fill a staff vacancy. She said management intended to hire a third CNA at night so rounds could consistently be completed. Review of resident 6's EMR revealed that he admitted to the facility on 6/3/25. His 3/5/26 BIMS assessment score was 3, which indicated his cognition was severely impaired. He had a diagnosis of mood disorder, dementia (a group of symptoms affecting memory, thinking, and social abilities), and a history of transient ischemic attacks (a "warning stroke" or a "mini stroke," when blood flow to the brain was temporarily blocked). Resident 6's 12/18/25 MDS assessment revealed that he was incontinent of bladder and frequently incontinent of bowel. His 3/16/26 care plan indicated that he required daily staff assistance with toileting, and that he was to be repositioned every two hours. Resident 6's care plan included a focus on potential skin integrity impairment related to incontinence of bowel and bladder, with a 10/7/25 intervention to check, change, and reposition him every two to three hours and PRN (as needed). His 6/4/26 Braden Scale assessment score was 15, which indicated that he was at high risk for developing a pressure sore, and that his skin was often very moist. Night shift documentation for 6/15/26 did not reveal any checks for resident 6. Night shift documentation for 6/16/26 revealed that he was checked once and was incontinent at 3:03 a.m. The CNA task documentation spanning from 6/4/26 to 6/16/26 indicated he was incontinent of urine three to four times each day. The 6/16/26 night shift CNA sheet indicated resident 6 needed assistance with toileting and was to have "check and change" completed during the staff's rounds at night due to incontinence. 20. Interview on 6/16/26 at 1:48 p.m. with CNA M, who worked the day shift, revealed that CNA Q was assigned to her hallway last night. CNA M said it was unusual to find residents 1, 2, and 3 "that wet" in the morning when she started her rounds. She documented each time a resident urinated if the resident's EMR prompted her to do so. She knew how to care for the residents because she referenced the CNA sheets, but she did not feel the			F0684			

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F0684 SS = E	Continued from page 9 CNA sheets were updated to reflect the residents' current care needs. CNA M was unsure how often the CNA sheets were updated and thought the night nurse updated them. 21. Interview on 6/16/26 at 2:07 p.m. with assistant director of nursing (ADON) C revealed she updated the CNA sheets, which indicated who needed to be checked and changed or offered to use the bathroom. The night nurses used to update the CNA sheets, but they found they were not getting updated. If the resident had an every two-hour task in the EMR to document on, she expected the CNA to document on that every two hours to indicate whether or not the resident was incontinent. She did not know what process was currently in place to ensure residents were not left lying in urine in the morning. 22. Interview on 6/17/26 at 6:00 a.m. with CNA J revealed that the night shift was from 10 p.m. to 6 a.m. and rounds were to be completed at midnight, 2 a.m. and 4 a.m. 23. Interview on 6/17/26 at 7:09 a.m. with CNA F revealed she did not receive any education prior to her shift starting on 6/17/26 on resident toileting and the "check and change" policy since 6/16/26 and she did not work on 6/16/26. She ensured that residents were not left in soiled incontinence briefs or bedding by checking residents every two hours and before and after meals for all residents. 24. Interview on 6/17/26 at 10:19 a.m. with CNA M revealed that residents 5 and 6 should be closely monitored to ensure frequent, timely care so their linens stay dry. She said resident 4 will take himself to the bathroom throughout the night. The facility's standard practice was to check on every resident at least every two hours. 25. Interview on 6/17/26 at 2:18 p.m. with DON B revealed she was completing an investigation regarding the six residents who were found wet on the morning of 6/16/26. She updated the six residents' care plans to reflect new interventions to "toilet/reposition every two-three hours and as needed." The updated care plans were placed in a binder at the nurse's station for the staff to read. She updated the CNA sheets to reflect a two-hour "check and change" schedule for the six residents. DON B was auditing CNA rounds based on a	F0684			

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F0684 SS = E	Continued from page 10 resident's concern that the staff were not offering residents assistance to the bathroom. The audits included checking to see if residents' incontinence briefs were dry and whether they were changed during the hours she worked, typically from 8 a.m. to 5 p.m. For night shift audits, DON B completed a chart review. The night shift nurses were responsible for ensuring the residents were dry, but they did not use the audit forms. The nurses were responsible for ensuring CNAs completed their task documentation in the resident's EMR. DON B expected the CNAs to document the residents' incontinent status each time they were checked, in accordance with the scheduled time and frequency listed in the resident's EMR. Walking rounds were completed, when the current CNAs went from room to room with the oncoming shift CNAs to give updates. This process was recently implemented but not yet enforced. The nurses and CNAs were to let her know when the residents' needs changed so she could update their EMR. The staff knew how to care for the residents by looking at the CNA sheets and reading updates in a binder located at the nurses' station. The CNA sheets used to be updated by the night nurses, but that was not being done, so ADON C was now responsible for updating the CNA sheets. She said this was the first time she was aware of the severity of the issue of residents being found incontinent in the morning. CNAs were taught incontinent care techniques at several points throughout their training, before working their scheduled shifts alone. Their training included a three-week online CNA curriculum, a 16-hour skills training observed by a registered nurse, and observed care performed during the eight or ten shifts they work alongside experienced CNAs. The six residents listed in the 6/16/26 FRI were dependent upon the facility staff to ensure their quality of care, and the incident portrayed staff neglect. She stated, "They [the staff] said they changed the residents, but clearly it wasn't done." 26. Interview on 6/17/26 at 3:56 p.m. with administrator A revealed that her leadership staff would be "taking a comprehensive look at the facility's bowel and bladder protocol." Prior to the 6/16/26 FRI, she was not aware of any incontinence concerns. She said her team was investigating	F0684			

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F0684 SS = E	Continued from page 11 multiple variables of incontinence care by conducting bowel and bladder assessments and analyzing incontinence product use. She intended to join the nurses to conduct random audits of all residents to ensure they received prompt toileting care. She expected the audits to be in-person, physically checking the residents and rooms, rather than just reviewing the CNA task logs. She expected staff to will follow the residents' care plans and "lay eyes on that [incontinence] brief every two hours," as well as seek assistance when the residents refused care. 27. Review of the provider's 12/1/19 director of nursing job description revealed that "The Director of Nursing is responsible for the planning, development and overall operation of the Nursing Department which ensures guests receive quality care 24 hours a day." It indicated the following essential job functions "plans, directs, and supervises the activities of the nursing staff. Ensures the nursing department is in compliance with federal, state, and local regulations. Responsible for providing consistent and sufficient staff for guest needs as well as regulatory requirements. Responsible for training and educating staff members. Ensure each guest receives person centered care supervises all nursing staff." 28. Review of the provider's 5/14/25 Nursing Care Standards policy revealed that "Incontinent residents shall be checked according to their individualized assessment and should have partial baths and clean linens promptly each time the bed or clothing is soiled. Peri-care is provided after each incontinence episode. ... Residents who use the toilet and need assistance should be offered/assisted to use the toilet at least every two to three hours or per their individualized plan of care." 29. Review of the provider's 5/14/25 Skin and Pressure Injury Prevention Program revealed that residents who have the risk factor for pressure injury related to incontinence were to be routinely checked for incontinence and have their skin cleaned when soiled. 30. Review of the provider's 5/13/26 South Dakota Department of Health (SD DOH) facility reported incident (FRI) revealed that on 5/10/26, resident 5 was left unaccompanied in the dining room for several hours following the evening meal. The report revealed that camera footage showed resident 5	F0684			

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F0684 SS = E	Continued from page 12 eating from 6:51 p.m. until 7:21 p.m. He remained in the dining room until contracted travel CNA Z wheeled him out at 10:17 p.m. The incident was brought to DON B's attention by resident 5's family member, who was told by another resident's family member that she saw resident 5 alone in the dining room late that evening. 31. Review of resident 5's EMR revealed he needed assistance to go to and from meals and eat his meals, and that he had a BIMS assessment score of 11, which indicated his cognition was moderately impaired. His care plan indicated he was at risk for skin impairment due to limited mobility and incontinence, and that he was dependent upon the staff to complete all activities of daily living including bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting. His care plan included an intervention from 10/25/25 that read, "Please remove me from the dining room promptly after meals and assist me in laying down to rest and relieve pressure from sitting." Resident 5's care plan was updated on 5/13/26 to include a new intervention that read, "I will be laid down immediately after meals." The updated care plan was highlighted and placed in a binder at the nurse's station for all staff to read at the start of their scheduled shift. As of 6/16/26, nine of the provider's 64 staff members had signed the in-service sheet acknowledging that they had read resident 5's updated care plan. 32. Interview on 6/16/26 at 9:02 a.m. with DON B and RNC Y revealed that resident 5 frequently complained that his family member wanted the staff to have him lie down after meals, so the staff sometimes let him stay in the dining room for a while before going to his room. DON B said resident 5 was usually in the dining room a half hour before mealtime and could take several hours to finish a meal. 33. Review of audits conducted by RNC Y and administrator A from 5/14/26 to 6/5/26 revealed that resident 5 remained in the dining room for more than two hours after supper had concluded on 5/27/26 (left the dining room at 7:49 p.m.), 5/28/26 (left the dining room at 7:55 p.m.), and 6/1/26 (left the dining room at 7:43 p.m.). 34. Observation in the dining room on 6/16/26 revealed that at 11:30 a.m., staff brought resident 5 to a table with other residents who received mealtime assistance. After he finished eating, staff took resident 5 back to his room at 1:54 p.m.	F0684			

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F0684 SS = E	Continued from page 13 Observation in the dining room on 6/17/26 revealed that staff brought resident 5 to the same table for breakfast at 7:30 a.m. He finished eating and staff helped him leave the dining room at 9:45 a.m. 35. Interview with resident 5's family member on 6/16/26 at 3:52 p.m. revealed that she recalled two other times, both in early May, when friends reported seeing resident 5 in the dining room late at night: once at 8:30 p.m. with other residents, and another time at 7:30 p.m. with the dining room lights turned off. She believed the facility was "short staffed" and that RNC Y and DON B were monitoring the dining room to ensure that resident 5 was not left alone again. 36. Interview on 6/17/26 at 11:03 a.m. with contracted travel CNA Z revealed that the staff assisted many residents back to their rooms during the two hours following mealtimes. She stated, "Call lights are going off after supper because residents want to get to bed right away,. It's a very busy time." CNA Z recalled that after supper on 5/10/26, she had glanced into the dining room and thought all the residents had returned to their rooms. The CNAs were assigned to one of two hallways during their scheduled shift, and it was their responsibility to assist all residents in that hallway. She expected another staff member to let her know if one of her residents needed to be assisted after mealtime. 37. Review of the All-staff meeting in-service sheets from 5/13/26 to 5/15/26 to educate the staff on abuse and neglect revealed the meeting handouts referenced resident 5's incident on 5/10/26 as "resident isolation: intentionally ignoring residents or limiting social interaction without clinical reason." Forty-five of the provider's 64 staff members had signed the all-staff meeting in-service sheets acknowledging that they had received education on abuse, neglect, and resident 5's incident on 5/10/26. 38. Review of the provider's 5/14/25 Care Plans policy revealed that care plans were maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence.	F0684		