STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435072	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN SISTERS LIVING CENTER	1201 HWY 71 SOUTH , HOT SPRINGS, South Dakota, 57747

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/11/25 through 8/14/25. Seven Sisters Living Center was found not in compliance with the following requirements: F658, F698, and F699. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/11/25 through 8/14/25. The area surveyed was potential resident abuse related to two traveling CNAs forcing a resident to go to the dining room for a meal service. Seven Sisters Living Center was found in compliance.	F0000		
F0658 SS = E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider failed to ensure Abnormal Involuntary Movement Scale (AIMS) assessments were routinely completed to evaluate for signs of adverse effects of antipsychotic medication use as a means to potentially reduce the risk for adverse outcomes for five of the five sampled residents (4, 7, 8, 22, and 31) who received antipsychotic medications. Findings included: 1. Record review of resident 4's electronic medical record (EMR) revealed: *He was admitted on 4/24/24. *He was diagnosed with type 2 diabetes (a condition	F0658		

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 9.4.2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435072	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

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F0658 SS = E	Continued from page 1 involving disruptions in how the body regulates blood sugar), paranoid schizophrenia (a mental health disorder with symptoms of delusions and hallucinations), anxiety disorder, depression, and cognitive communication deficit. *His Brief Interview for Mental Status (BIMS) assessment score was a 15, which indicated his cognition was intact. *He was given one risperidone 0.25 milligrams (mg) tablet by mouth one time a day in the morning. Risperidone is an antipsychotic medication (a medication used to treat a variety of mental health conditions). *He was given two risperidone 0.25 mg tablets by mouth one time a day in the evening. *He was given one sertraline HCl 100 mg tablet by mouth one time a day for depression. *No documentation in his EMR indicated that an AIMS assessment had been completed. 2. Review of resident 7's electronic medical record (EMR) revealed: *She was admitted on 4/9/25. *She was diagnosed with Alzheimer's disease (a progressive disease that destroys memory and other mental functions), anxiety disorder, major depressive disorder, and delirium (a sudden change in thinking that leads to confusion). *Her Brief Interview for Mental Status (BIMS) assessment score was 5, which indicated she had severe cognitive impairment. *She was given one olanzapine 5 milligrams (mg) tablet by mouth, an antipsychotic medication, every evening and every twelve hours as needed. *She was given one lorazepam 0.5 mg tablet by mouth, a benzodiazepine medication (a medication used to slow activity in the brain to produce a calming effect), every eight hours as needed. *No AIMS assessment had been completed. 3. Review of resident 8's EMR revealed:	F0658	The Director of Nursing or designee completed Abnormal Involuntary Movement Scales (AIMS assessments) for residents 4, 7, 8, 22, and 31. The Director of Nursing or designee will audit each resident record to ensure AIMS assessments are complete for every resident according to policy. The Director of Nursing or designee will monitor resident records monthly for three months to ensure an AIMS assessment is completed according to policy. The Director of Nursing or designee will report audit results to the quality assurance team monthly for three months for further recommendation. The Director of Nursing or designee will educate licensed nurses regarding the appropriate completion of AIMS assessments. The Administrator or designee will ensure an appropriate psychotic medication policy is available and all licensed nurses are educated regarding the policy. The policy will require AIMS assessments upon admission, quarterly, or upon significant change.	9/28/2025

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F0658 SS = E	Continued from page 2 *He was admitted on 1/23/25. *He had a diagnosis of dementia (a group of symptoms affecting memory, thinking, and social abilities). *His BIMS assessment score was 3, which indicated he had severe cognitive impairment. *He was given one-half of a 25 mg (12.5 mg) quetiapine fumarate tablet by mouth, an antipsychotic medication, at bedtime through his gastrostomy tube (a feeding tube inserted through the abdomen into the stomach). *No AIMS assessment had been completed. 4. Review of resident 22's EMR revealed: *She was admitted on 1/11/23. *She was diagnosed with vascular dementia (problems with memory, thinking, and behaviors caused by disruption of blood flow to the brain) with agitation, and depression. *Her BIMS assessment score was 3, which indicated she had severe cognitive impairment. *She was given one quetiapine fumarate 50 mg tablet by mouth at bedtime, one 25 mg tablet at bedtime, and one-half of a 25 mg tablet (12.5 mg) by mouth at noon. *She was given one fluoxetine hydrochloride 20 mg tablet by mouth, a selective serotonin reuptake inhibitor (SSRI) medication (a medication used to treat a variety of mental health conditions), once daily. *Her last AIMS assessment was completed on 9/28/23. 5. Review of resident 31's EMR revealed: *She was admitted on 3/31/22. *She had a diagnosis of Alzheimer's disease. *Her BIMS assessment score was 99 because she did not answer the questions, and the staff interview was completed. -She had memory impairment and severe difficulty with daily decision-making. *She was given one-half of a quetiapine fumarate 25 mg	F0658		

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F0658 SS = E	Continued from page 3 tablet (12.5 mg) by mouth daily at noon and bedtime. *Her last AIMS assessment was completed on 3/5/24. 6. Interview on 8/13/25 at 8:30 a.m. with lead resident care manager (LRCM) C revealed: *Residents who received psychotropic medications should have had an assessment completed routinely to monitor for adverse side effects. *She stated, "AIMS assessments should have been completed upon admission, quarterly, and with any significant change in status for residents." *AIMS assessments should have been completed by MDS coordinator D to assess residents for psychotropic medication side effects. *She verified that she was unable to find recently completed AIMS assessments for residents on psychotropic medications. *She stated that the facility currently had no "psychotropic medication" policy and was unable to provide a related policy for review. 7. Interview on 8/14/25 at 11:25 a.m. with MDS Coordinator D revealed: *She confirmed that she had not completed any resident AIMS assessments upon admission or during the Minimum Data Set (MDS) process.	F0658		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, record review, and policy review, the provider failed to ensure that one of one sampled resident (3) who received dialysis (a treatment for kidney failure that removes waste and	F0698		

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F0698 SS = D	Continued from page 4 excess fluid from the blood), received services consistent with professional standards of practice by not having documented the resident's care needs and not having provided documented evidence that the resident was monitored for complications or significant changes in clinical status, including bleeding and hypotension (low blood pressure). Findings include: 1. Interview on 8/12/25 at 9:16 a.m. with resident 3 in her room revealed: *She was lying in her bed, covered with a blanket. *She stated she received dialysis on Monday, Wednesday, and Friday mornings. *She was transported from the facility to receive her dialysis treatments. *On dialysis days, she had breakfast at the facility and was provided with a sack lunch to take with her to dialysis. *The staff would "sometimes" check her vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) when she returned after dialysis. *She stated, "You have to be patient when you ask for help. You usually have to wait a long time." 2. Interview on 8/13/25 at 11:33 a.m. with certified medication aide (CMA) H about the process followed when resident 3 returned from dialysis revealed: *There was no formal process to follow when a resident returned from dialysis. *There was no post-dialysis assessment completed for resident 3 when she returned to the facility after dialysis. *It was up to resident 3 to decide what happened when she returned from dialysis. If she wanted to stay up after dialysis, they would help her into her chair, and if she preferred to lie down, they would assist her into her bed. 3. Interview on 8/13/25 at 11:38 a.m. with registered nurse (RN) I about the process followed when resident 3	F0698	The Director of Nursing or designee will complete a dialysis assessment for resident number three and complete a nursing progress note pre and post dialysis. The Director of Nursing or designee will audit all residents to ensure any residents receiving dialysis are assessed according to policy. The Director of Nursing or designee will audit all resident records (monthly for three months) of residents receiving dialysis, ensuring a dialysis assessment is completed according to policy. The Director of Nursing or designee will report audit findings to the quality assurance team monthly for three months for further recommendation. The Director of Nursing or designee will educate all licensed nurses regarding the pre and post dialysis process and policy.	9/28/2025

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F0698 SS = D	Continued from page 5 returned from dialysis revealed: *"She usually tells us what she wants to do when she gets back." *Resident 3 usually said she was hungry and wanted to eat her sack lunch when she returned. *There was no formal process for assessment or documentation of clinical status after dialysis. 4. Interview on 8/13/25 at 4:31 p.m. with lead resident care manager (LRCM) C about the process revealed: *The dialysis center would send a communication form back to the facility with resident 3. *She would expect the staff to be checking resident 3's vital signs and looking at the dressing over her port (a type of dialysis access surgically placed under the skin that allows for repeated needle access for dialysis treatments) to make sure the dressing was clean, dry, and intact. *She stated that it "depends on what she [resident 3] wants. If she wants to go straight to the dining room, it may be later that day, after we get her back to her room and in bed before vital signs are checked." *She confirmed that without checking resident 3's vital signs and dressing after dialysis, it would be difficult to monitor for changes in her clinical status. *She stated there was "room for improvement" with that process. 5. Review of resident 3's electronic medical record (EMR) revealed: *She was admitted on 9/5/24. *She had a 5/23/25 Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated her cognition was intact. *She had a 9/9/24 initiated care plan goal of "The resident will have immediate intervention should any s/sx [signs/symptoms] of complications from dialysis occur through the review date." *The 9/9/24 care plan interventions associated with	F0698		

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F0698 SS = D	Continued from page 6 that goal included: -"Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis three times a week; Monday, Wednesday, and Friday." -"Monitor/document/report PRN [as needed] any s/sx of infection to access site: Redness, Swelling, warmth or drainage." -"Work with resident to relieve discomfort for side effects of the disease and treatment." *Resident 3's blood pressure and heart rate documentation from January through July of 2025 indicated: -In January, her blood pressure and heart rate were documented once, on 1/25/25. -In February, her blood pressure and heart rate were documented on 2/14, 2/15, 2/16, and 2/28. -In March, her blood pressure and heart rate were documented on 3/8, 3/14, and 3/22. -In April, her blood pressure and heart rate were documented on 4/2, 4/5, and 4/19. -In May, her blood pressure and heart rate were documented on 5/3, 5/4, 5/17, 5/18, 5/19, 5/24, and 5/31. -In June, her blood pressure and heart rate were documented on 6/7, 6/14, and 6/21. --There were only twenty-one days from January through July 2025 that had a blood pressure and heart rate documented. ---Only 5 of those twenty-one days were scheduled dialysis days. 6. Interview on 8/14/25 at 12:48 p.m. with chief nursing officer (CNO) B revealed: *They had just identified that they needed a post-dialysis assessment tool or form to clarify the expectations for vital sign monitoring and assessment of residents who received dialysis. *Staff had not received any dialysis-specific training.	F0698		

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F0698 SS = D	Continued from page 7 *She confirmed that without assessing a resident after dialysis, it would be difficult to monitor for changes in clinical status. 7. Review of the provider's 2001 "End-Stage Renal Disease, Care of a Resident with" policy revealed: *"Policy Statement -Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care." *"Policy Interpretation and Implementation -Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. -Education and training of staff includes, specifically: --the nature and clinical management of ESRD (including infection prevention and nutritional needs); --the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis; --signs and symptoms of worsening condition and/or complications of ESRD; --how to recognize and intervene in medical emergencies such as hemorrhages and septic infections; --timing and administration of medications, particularly those before and after dialysis;" -"The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care."	F0698		
F0699 SS = E	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers	F0699		

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F0699 SS = E	Continued from page 8 that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure four of four sampled residents (6, 7, 15 and 26) were screened for a history of trauma upon their admission to the facility. Findings include: 1. Interview on 8/12/25 at 9:36 a.m. with resident 6 in her room revealed: *She was dressed and sitting in her recliner with a blanket and a stuffed cat on her lap. *Her room is decorated with lots of pictures and paintings of butterflies. She stated she enjoyed painting. *She stated that sometimes she would get "really mad," and then she's "not the nicest girl." *She said, "I had a father, who you wouldn't call a father, because he would come home and he would use me. He would have his fun with me, and he would laugh about it. He was a mean man. But I got over it, I don't know how." *Later in the interview, when asked about the food at the facility, she stated, "I should eat more, I want to be strong. I want to be strong because I don't ever want anyone touching me again, that's not supposed to be." Review of resident 6's electronic medical record (EMR) revealed: *She had a 7/9/25 Brief Interview for Mental Status (BIMS) assessment score of 6, which indicated she had severe cognitive impairment. *She had a 6/27/22 initiated care plan intervention to "Monitor for s/s [signs/symptoms] of depression, previous history of childhood abuse/PTSD [post-traumatic stress disorder] possible symptoms. Behavioral Health and her Physician have been made aware of this past history. Give her time to talk/express any feeling. Notify her Charge Nurse if symptoms persist."	F0699	The Social Services Director or designee will complete Trauma Informed Care Assessments for residents 6, 7, 15, and 26 and update their care plans as necessary. The Social Services Director or designee will ensure each resident has a Trauma Informed Care Assessment completed and care plans accurately address care needs. The Social Services Director or designee will audit resident records (monthly for three months) to ensure Trauma Informed Care Assessments are completed. The Social Services Director or designee will report audit results to the quality assurance team monthly for three months for further recommendation. The Social Services Director or designee will educate all licensed nurses regarding Trauma Informed Care and the facility policy to address trauma.	9/28/2025

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F0699 SS = E	Continued from page 9 *She did not have a diagnosis of PTSD (a mental health condition that can develop after experiencing a traumatic event) or depression, and had not been screened or assessed for trauma triggers. Interview on 8/13/25 3:08 p.m. with social services manager (SSM) E revealed: *She stated, "I do the MDS, [Minimum Data Set 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), and if I notice a resident is depressed, I let the physician's nurse know. I believe [medical director K] makes the referral for mental health services." *She did not have a specific assessment to have screened residents for trauma history or to have addressed trauma triggers. *She stated, "Is that something we're supposed to be doing? We are not screening every resident for trauma. Is that something that is supposed to be done on admission?" Interview on 08/13/25 3:56 p.m. with lead resident care manager (LRCM) C revealed: *Psychiatry would screen all residents who have a psychotropic medication prescribed. *She stated, "We are not screening all residents for trauma now, but we will be in the future." *Residents who did not have a mental health diagnosis were not being screened for a history of trauma. *She stated, "Trauma-informed care has never been a part of the training curriculum here, so we had to add it, and now everyone will be getting that training." 2. Review of resident 7's electronic medical record (EMR) and comprehensive care plan revealed: *She was admitted on 4/9/25. *Her BIMS assessment score was 5, which indicated she had severe cognitive impairment. *She had diagnoses of anxiety disorder, major depressive disorder (a mental condition characterized by a persistently depressed mood and loss of pleasure	F0699		

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F0699 SS = E	Continued from page 10 or interest in life), and Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions). *She was taking medications daily to treat her depression, anxiety, and mood. *She had a history of abuse and trauma from her ex-husband. -She was hospitalized numerous times during their marriage. *She had a difficult time adjusting to her admission into the facility and being away from her son. *There was no documentation to support that she was screened for a history of trauma upon her admission to the facility. *She had a 4/22/24 initiated care plan with no identified focus that specifically addressed her trauma. 3. Interview on 8/14/25 at 2:00 p.m. with LRCM C and medical provider J regarding resident 7 revealed: *They both confirmed the resident had a history of trauma and abuse by her ex-husband during their marriage. *Resident 7 received therapy from medical provider J every two weeks. *Resident 7 experienced delusions and hallucinations, and medication management with adjustments was necessary. *LRCM C confirmed that no trauma screening was completed upon resident 7's admission. *LRCM C and medical provider J both agreed that trauma screenings should have been completed upon admission with residents with a history of abuse or trauma. *LRCM C confirmed that there was no current process in place for screening residents for trauma history on admission. *Interview with social service manager (SSM) E was attempted on 8/14/25 at 3:06 p.m., but she was	F0699		

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F0699 SS = E	Continued from page 11 unavailable due to scheduled resident care conference meetings. 4. Observation and interview on 8/12/25 at 10:39 a.m. with resident 26 revealed: *She was lying in bed with her knees bent and the blankets pulled up over them. *She stated she had been at the facility for two weeks. *She stated she had PTSD (post-traumatic stress disorder) from the Oklahoma City bombing. *She had seen a psychiatrist, but that was 20 years ago. Record review of resident 26's EMR revealed: *She was admitted on 7/23/25. *Her BIMS assessment score was 15, which indicated her cognition was intact. *She was scheduled to see medical provider J on 8/14/25 to set up a scheduled psychiatric plan. *She had diagnoses of PTSD and hypertension (high blood pressure). *There was no documentation to support that she was screened for PTSD upon admission to the facility. *Her care plan had not mentioned her PTSD or any interventions. 5. Observation and interview on 8/12/25 at 11:20 a.m. with resident 15 revealed: *He was in his closet sorting his clothes. *He was clean-shaven and well-dressed. *He stated he had been at the facility for seven and half months. *He had PTSD and was seeing a psychiatrist at the local VA (United States Department of Veterans Affairs). Record review of resident 15 EMR revealed:	F0699		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435072	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN SISTERS LIVING CENTER	1201 HWY 71 SOUTH , HOT SPRINGS, South Dakota, 57747

(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
F0699 SS = E	Continued from page 12 *He was admitted on 12/10/24. *His BIMS assessment score was a 15, which indicated his cognition was intact. *He had diagnoses of bipolar disorder (a disorder with episodes of mood swings) and PTSD. *There was no documentation to support he was screened for trauma for PTSD upon admission to the facility. *His care plan had mentioned his PTSD. Review of the provider's 2001 Trauma-Informed Care and Culturally Competent Care policy revealed: Purpose: "To address the needs of trauma survivors by minimizing triggers and/or re-traumatization." Resident Screening: "1. Perform universal screening of residents, which includes a brief, non-specialized identification of possible exposure to traumatic events." "3. Screening may include information such as: a. trauma history, including type, severity and duration; b. depression, trauma-related or dissociative symptoms; c. risk for safety (self or others); d. concerns with sleep or intrusive experiences; e. behavioral, interpersonal or developmental concerns; f. historical mental health diagnosis; g. substance use; h. protective factors and resources available; and i. physical health concerns." "4. Utilize initial screening to identify the need for further assessment and care."	F0699		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435072	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN SISTERS LIVING CENTER	1201 HWY 71 SOUTH , HOT SPRINGS, South Dakota, 57747

(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 8/13/2025. Seven Sisters Living 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	(X6) DATE
[signature]	CEO	9.4.2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435072	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - SEVEN SISTERS B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN SISTERS LIVING CENTER	1201 HWY 71 SOUTH , HOT SPRINGS, South Dakota, 57747

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 03	INITIAL COMMENTS A recertification survey was conducted on 8/13/2025 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Seven Sisters Living 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 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
[signature]	CEO	9.4.2025

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10630	A. BUILDING: _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN SISTERS LIVING CENTER	1201 HWY 71 SOUTH HOT SPRINGS, SD 57747

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 47780 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 8/11/25 through 8/14/25. Seven Sisters Living Center was found in compliance.	S 000		
S 000	Compliance/noncompliance Statement Surveyor: 47780 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/11/25 through 8/14/25. Seven Sisters Living Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 9.4.2025