STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	609 EAST 7TH PLATTE, SD 57369

(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
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/4/25 through 2/5/25. The area surveyed was neglect related to a resident who may not have received required care by staff. Platte Care Center was found not in compliance with the following requirements: F609 and F610.	F 000		
F 609 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 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	F 609	Platte Care Center acknowledges that it failed to report an allegation of neglect on 12/26/2025 after a note was left on the DON's desk. This note was an allegation of neglect, that did not get reported during the mandatory reporting timeline. Changes to Platte Care Center's system will be changed to achieve sustained compliance. Changes include: staff education and form changes. Staff education for nurses and CNA's was completed on 2/11/2025 and 2/13/2025. Education included reportable incidents to the department of health, including allegations of abuse and neglect. Education was also done on how to report to the department of health and the timelines required for the reportable incident. Additionally, an online mandatory assigned learning module will be assigned to all staff. This learning module will cover the definitions of abuse, neglect, and misappropriations of funds, the effects of such incidents, actions to take when there is belief one of these occurred (including reporting), and prevention of abuse and neglect. Reporting timelines will be placed in the Tip Sheet Binder for easy reference. The Corrective Action Form will have edits to the original form to include bullet points under the abuse and neglect box. The added verbiage will instruct staff to file a report with the department of health using the tip sheets located in the Tip Sheet binder, as well as to text the administrator immediately for notification. Corrective Action Forms with these boxes checked, will then be placed in the administrator's mailbox or office. The Administrator will be able to review and monitor the Corrective Action Forms, and compare them with the text message received, as well as if the state report was filed to ensure successful system changes. The Administrator will conduct this monitoring every time there is a form, text message, and/or state report sent to the administrator and will be monitoring until the next annual state survey. This monitoring data will be added to the Quality Dashboard in a separate row and will be tallied monthly and sent to Quality Assurance Meeting Quarterly and QAPI meetings that are held at least Quarterly for discussion.	3/4/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cordell Muilenburg	Administrator	3-4-25

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 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.

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F 609	Continued From page 1 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of South Dakota Department of Health (SD DOH) complaint, interview, record review, and policy review, the provider failed to report suspected neglect for one of one (1) sampled residents. Findings include: 1. Review of the SD DOH complaint filed anonymously on 12/31/2025 revealed: *On 12/28/24, the anonymous writer observed resident 1 in a soiled (incontinent) brief after CNA D had documented changing resident 1's brief at 4:00 a.m. *The anonymous writer reported at 4:00 a.m., the brief was dated 0000 (indicating it was changed at 12:00 a.m.), concluding the brief could not have been changed at 2:00 a.m. by CNA D. *The anonymous writer reported that night shift staff had written multiple reports of CNA D's neglectful behavior, but the reports had not led to any change in CNA D's behaviors. 2. Review of the provider's "Platte Care Center Avera Health Corrective Action Plan" form submitted by LPN C revealed: *A CNA brought it to LPN C's attention that CNA D had not been completing required checks on residents but was falsely documenting she was. *LPN C verified one of the residents was incontinent of urine. *When LPN C confronted CNA D, "CNA D told me [LPN C] I was in for a world of "shit" if reported. *CNA A felt she was being targeted by LPN C. *LPN C told CNA D she had been getting complaints from other CNAs alleging CNA D was	F 609		

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F 609	Continued From page 2 not performing her job duties. *LPN C wanted to take a picture of a resident's incontinent brief, but CNA D would not allow this and "made a scene." *LPN C then sent the DON a message to call and discuss the incident. 3. Phone interview on 2/5/25 at 10:42 a.m. with a staff member who requested to remain anonymous revealed: *Some of the CNAs would lie about having completed their work duties. *CNA D had made verbal threats before to a night shift nurse. *The anonymous interviewee was aware of at least three staff members that had reported CNA D neglecting her duties to director of nursing (DON) B and administrator A. *The anonymous interviewee reported that staff are fearful of retaliation from management. 4. Interview on 2/5/25 at 12:07 p.m. with administrator A revealed: *He considered cares not getting done was neglect. *It was his expectation that if two staff did not get along or accused each other of abuse/neglect, the floor nurse was to investigate the allegations and report the investigation findings to DON B. *He reported education had been provided on how to file a report with the SD DOH to the nursing staff on 8/26/24 and to CNAs on 8/27/24 at staff meetings. *There were step-by-step instructions on how to file a report with the SD DOH in the medication room "tip sheets binder." *It was his expectation that these allegations should have been reported to the SD DOH.	F 609		

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F 609	Continued From page 3 5. Interview on 2/5/25 at 2:31 p.m. with RN F regarding SD DOH online reporting revealed: *She was aware of the online reporting site. *She had used it to report fall incidents. *She had not used it to report allegations of neglect, she would report allegations of neglect directly to DON B for investigation. 6. Review of the provider's 1/2025 Abuse Prohibition Policy & Reporting of Crimes (in Long Term Care, Hospital, & Home Settings) policy revealed: *"Neglect" Neglect is the failure of the facility, its employees or service provider to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. *The facility will thoroughly investigate all alleged violations and will prevent further potential abuse while the investigation is in progress. *"Policy: Platte Health Center Avera has established a "zero tolerance" policy for any form of abuse or neglect toward any resident/patient."	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all	F 610		

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F 610	Continued From page 4 investigations 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) complaint review, interview, record review, and policy review, the provider failed to thoroughly investigate allegations of neglect of one of one sampled resident (1) by certified nursing aide (CNA) D and failed to adequately document the process for reporting neglect. Findings include: 1. Review of the SD DOH complaint was anonymously on 12/31/2025 revealed: *On 12/28/24, the anonymous writer observed resident 1 in a soiled (incontinent) brief after CNA D had documented having changed resident 1's brief at 4:00 a.m. *The anonymous writer reported at 4:00 a.m., the resident's incontinence brief was dated 0000 (indicating it was changed at 12:00 a.m.), and concluded the brief could not have been changed at 2:00 a.m. by CNA D. *The anonymous writer reported that the night shift staff had written multiple reports of CNA D's neglectful behavior, but the reports had not led to any change in CNA D's behaviors. 2. Interview on 2/5/25 at 12:07 p.m. with administrator A revealed: *Reports of abuse or neglect were to be reported to the SD DOH by director of nursing (DON) B during daytime hours and by the night shift nurse during nighttime hours.	F 610	Platte Care Center acknowledges that is failed to thoroughly investigate allegations of neglect on 12/26/2025 after a note was left on the DON's desk. This note was an allegation of neglect that did not get reported in the mandatory timeline, resulting in the investigation not being completed thoroughly. Changes to Platte Care Center's system will be changed to achieve sustained compliance. Changes include: staff education and nightly rounding changes. At night, rounds will be conducted with at least two staff members to ensure that all cares are being done. Staff education for nurses and CNA's was completed on 2/11/2025 and 2/13/2025. Education included reportable incidents to the department of health, including allegations of abuse and neglect. Education was also done on how to report to the department of health and the timelines required for the reportable incident. Additionally, an online mandatory assigned learning module will be assigned to all staff. This learning module will cover the definitions of abuse, neglect, and misappropriations of funds, the effects of such incidents, actions to take when there is belief one of these occurred (including reporting), and prevention of abuse and neglect. Reporting timelines will be placed in the Tip Sheet Binder for easy reference. The Corrective Action Form will have edits to the original form to include bullet points under the abuse and neglect box. The added verbiage will instruct staff to file a report with the department of health using the tip sheets located in the Tip Sheet binder, as well as to text the administrator immediately for notification. Corrective Action Forms with these boxes checked, will then be placed in the administrator's mailbox or office. The Administrator will be able to review and monitor the Corrective Action Forms, and compare them with the text message received, as well as if the state report was filed to ensure successful system changes. The Administrator will conduct this monitoring every time there is a form, text message, and/or state report sent to the administrator and will be monitoring until the next annual state survey. This monitoring data will be added to the Quality Dashboard in a separate row and will be tallied monthly and sent to Quality Assurance Meeting Quarterly and QAPI meetings that are held at least Quarterly for discussion.	3/4/2025

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F 610	Continued From page 5 *Instructions for reporting to the SD DOH could be found in the medication room in the "tip sheet binder." *He described neglect to surveyors as "cares not done." *It was his expectation that neglect allegations would be reported. *When asked if there had been any recent allegations of neglect, he replied "There have been rumors." *When asked how he would have expected rumors of neglect to be handled, he explained he expected staff to report the allegations to the nurse. -The nurse was to then investigate the allegations. -He thought the last rumors of neglect had occurred about two or three months ago. *He was not aware of any written reports of neglect allegations. 3. Follow-up interview on 2/5/25 at 1:30 p.m. with administrator A revealed: *On 12/26/24, a "Platte Care Center Avera Health Corrective Action Plan" form had been submitted to DON B by licensed practical nurse (LPN) C regarding suspected neglect by CNA D. *He had just received that form from DON B. *He was not aware that form had been received by DON B. *His statement regarding that form and the incident information included on it was "It should have been reported." 4. Review of the provider's "Platte Care Center Avera Health Corrective Action Plan" form submitted by LPN C revealed: *A CNA had reported to LPN C's that CNA D had not been completing the required checks on	F 610		

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F 610	Continued From page 6 residents and was falsely documenting that she had. *LPN C verified one of the residents had been incontinent of urine. *When LPN C confronted CNA D, CNA D replied "CNA D told me [LPN C] I was in for a world of "shit" if reported to management for not performing her required duties. *CNA D felt she was being targeted by LPN C. *LPN C told CNA D she had been getting complaints from other CNAs alleging CNA D was not performing her job duties. *LPN C wanted to take a picture of a resident's incontinent brief, but CNA D would not allow that and "made a scene." *LPN C then sent DON B a message to call and discuss the incident. 5. Interview on 2/5/25 at 2:10 p.m. with CNA E revealed: *If she witnessed abuse or neglect, she would first remove the resident from the immediate threat. *She would then report the abuse or neglect to the charge nurse. *It was her expectation that suspicion of abuse or neglect would be reported. 6. Interview on 2/5/25 at 2:47 p.m. with DON B revealed: *On the night of the above incident (12/26/26), she had missed a phone call from both LPN C and CNA D. *She later got a call from LPN F letting her know the "Platte Care Center Avera Health Corrective Action Plan" form had been placed on her desk. *The "Platte Care Center Avera Health Corrective Action Plan" form was placed on DON B's desk on 12/26/24 while DON B was on vacation.	F 610		

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F 610	Continued From page 7 *Upon her return from vacation, she interviewed CNA D about the accusation of not completing cares by LPN C. -CNA D was adamant her duties had been performed. *A follow-up communication with LPN C with the use of Volt (a messaging application on cell phone used by the facility for staff to communicate with each other) revealed CNA D had apologized to LPN C for yelling and refusing to talk to LPN C. *At this point, it was the DON's opinion the argument had been settled. 7. Review of the provider's 1/2025 Abuse Prohibition Policy & Reporting of Crimes (in Long Term Care, Hospital, & Home Settings) policy revealed: *"Neglect" Neglect is the failure of the facility, its employees or service provider to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. *The facility will thoroughly investigate all alleged violations and will prevent further potential abuse while the investigation is in progress. *"Policy: Platte Health Center Avera has established a "zero tolerance" policy for any form of abuse or neglect toward any resident/patient."	F 610		