STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435100	A. BUILDING _____ B. WING _____	C 06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET MANOR AVERA HEALTH	129 E CLAY ST IRENE, SD 57037

(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 6/16/25 through 6/18/25. Areas surveyed were potential resident to resident abuse, quality of care and resident safety regarding improper use of a mechanical lift. Sunset Manor Avera Health was found not in compliance with the following requirements: F600, F684 and F689.	F 000		
F 600 SS=D	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. §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 South Dakota Department of Health (SD OH) facility-reported incident (FRI), record review, observation, interview, and policy review, the provider failed to protect the resident's right to be free from sexual abuse by one of one sampled resident (3) who made unsolicited sexual advances towards one of one sampled resident (2). Resident 3 had a history of sexually	F 600	F 600 System correction: All nursing staff will be re-educated on incident reporting and the requirement for reporting to the State through the Facility-Reported Incidents (FRI) no later than 7/15/25 at the mandatory nurse's meeting. Education will include information from the 2567, a review of new and updated policies including the LTC Abuse Prohibition Policy updated 7/7/25, Incident Reporting and Investigation Policy developed on 7/7/25, State Reporting Policy developed on 7/7/25, along with being re-educated on the one to one (1:1) definition for resident #3. CNAs will be re-educated no later than 7/15/25 on the 1:1 definition for resident #3 and the new Incident Reporting and Investigation Policy and what their part will be for any incident they witness. A CNA meeting was completed on 7/8/25 that covered the information from the 2567, the 1:1 definition, the new incident investigation form they will be required to fill out if they are a witness to any incident and education on dealing with difficult residents or those with behaviors, ideas on how to re-direct them and examples of interventions. An all staff meeting is scheduled for 7/15/25 to educate staff in all departments on the new Incident Reporting and Investigation Policy with their part in filling out the new incident investigation form if they witness any type of an incident. Information will also be provided to all staff about the 2567. Continue on next page	07/15/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin R. Stockland
TITLE: Administrator
(X6) DATE: 07/11/2025

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 600	Continued From page 1 inappropriate behavior and required close supervision while in common areas around peers. Findings include: 1. Review of the SD FRI report dated 6/9/25 revealed: *The incident occurred on 6/7/25. *Residents 2 and 3 ambulated via wheelchairs independently. *Residents 2 and 3 were in a hallway unmonitored by staff. *Resident 3 propelled himself in his wheelchair up to resident 2 and rubbed her right leg then rolled away from her. *Certified nursing assistant (CNA) J talked to residents 2 and 3 in the hallway but had not separated the residents. *Resident 3 put hand sanitizer on his hands, rolled over to resident 2 and put some of the sanitizer on her hands, started to rub her lap, and touched her private area. *CNA J realized they were next to each other and removed resident 3 from the area and moved resident 2 into the dining room near the table. *CNA J notified the nurse of the situation. *Resident 2's vital signs (measurement of the body's basic functions) were as follows: blood pressure (BP) 153/78, pulse 68, oxygen saturation (level of oxygen in blood) 95 percent on room air. *Resident 2's doctor and family were notified of the incident. *Staff were reminded of the need for resident 3 to be monitored in the commons area at all times. 2. Observation and interview on 6/18/25 at 7:46 a.m. of camera footage from 6/7/25 with director of nursing (DON) B revealed: *On 6/7/25 at 10:43 a.m. residents 2 and 3 were	F 600	F 600 Continued from previous page Corrected to individual LPN E: When DON B was notified of incident that occurred on 6/7/25, DON B began investigation into the incident. DON B then submitted a FRI on 6/9/25 since LPN E did not complete an incident report or FRI on 6/7/25. Initial re-education was given to Nurse E about the need for the incident investigation and requirement of the FRI by DON B on 6/9/25 due to LPN E not following proper procedure when employee D reported incident to LPN E. On 06/18/25 LPN E was provided formal education and corrective action by DON B & HR director due to not following proper procedure during/after this incident. LPN E's corrective action was provided later due to issues with schedules. Corrected to individual CNA J: CNA J was from a temp agency and when it was discovered that she had not attempted to prevent the incident on 6/7/25, her company was contacted and she was put on the do not return (DNR) list for our facility on 6/9/25. Corrected to individual resident #3: Re-education was immediately given to nursing staff (nurses & CNAs) working in the unit as soon as the incident was discovered on 6/9/25 about resident #3 needing to be a 1:1 to prevent this type of incident. More formal education to help prevent resident #3 from touching resident #2 or other residents inappropriately is being presented to all nursing staff by 7/15/25 as noted above in system correction. Monitoring of system: DON, Admin or designee will monitor 50% of incident reports to be sure a FRI has been completed if necessary and that it has been initiated in a timely manner. DON, Admin or designee will also monitor the 1:1 for resident #3 to ensure it is being completed properly. Audits will be completed 2x/wk x 4 weeks, 1x/wk x 4 weeks and monthly x 4 months. Information from all audits will be reported to the QAPI team at monthly QAPI meetings by DON, Admin or designee.	

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F 600	Continued From page 2 in their wheelchairs in the challenging behavior unit (CBU) dayroom. *Resident 2 moved from the hall toward resident 3. *Resident 3 backed up toward resident 2, and rubbed his right hand on her right leg. *There were no staff in view at that time. *Resident 2 wheeled herself away from resident 3. *Resident 3 followed her and pushed on the right wheel of resident 2's wheelchair as he continued to follow her down the hallway. *At 10:45 a.m. CNA J came into view from the dining room, she went back into the dining room but did not enter or look down the hall where residents 2 and 3 were. -CNA J did not attempt to intervene or stop the interaction between the two residents. *Resident 2 wheeled herself back up the hall toward resident 3 who was getting hand sanitizer from the wall dispenser. -They had moved toward each other in the hall, but resident 2 then turned and went away away from resident 3. *No staff were seen in that area, resident 2 was seen seated in her wheelchair with her right side toward resident 3 who had moved toward her. *Resident 2 then turned and began to move. *CNA J was in the doorway but did not face them and turned back away from them. -CNA J went back into the dining room without attempting to stop the interaction between resident 2 and resident 3. *Resident 3 wiped his hands on his shirt. *Resident 2 turned back towards him and stopped herself by resident 3. *Resident 3 rubbed resident 2's hands, turned toward her, patted and rubbed her hand, and then moved his hand to her private area between her	F 600		

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F 600	Continued From page 3	F 600		

legs.
*At 10:52 a.m. resident 3 turned away and the two residents separated from each other.
-Resident 3 rolled back up the hallway.
*Resident 2 attempted to go into a room identified as hers by DON B.
*Resident 3 went back toward resident 2 but CNA J took him back toward the day room and dining room area.
*Licensed practical nurse (LPN) E did not come in to view on the footage during the interactions between residents 2 and 3.
*DON B agreed resident 3 had touched resident 2's private area between her legs, without her consent.
*DON B stated LPN E should have completed an assessment on resident 2 for the physical and emotional well-being and contacted her.
*DON B would have expected LPN E to have known to do those things as a nurse.
*DON B explained that the "1:1 within arm reach at all times" regarding residents 2 and 3 that was indicated on the hall sheets was to ensure residents had close monitoring.
-Resident 3 was easily agitated if staff had gotten too close to him.
-The staff had been instructed to remain in close vicinity of him so they could have intervened quickly when he exhibited inappropriate behaviors.
*DON B was out of the facility on 6/12/25 and there had been no further internal investigation completed from the 6/7/25 incident between resident 2 and 3 until today, 6/18/25.
-She had become aware of the incident on 6/9/25 but no internal investigation was initiated to rule out abuse and neglect at the time of the incident or at the time of her awareness.
*DON B thought the staff may have been in the

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F 600	Continued From page 4 bathroom when not in view on the footage. 3. Interview on 6/17/25 at 9:25 a.m. with housekeeper D regarding the above 6/7/25 incident revealed: *She had worked the day of 6/7/25 and had been cleaning the nurse's station in the manor unit which adjoined the CBU with double doors with windows when the incident occurred but could not remember the time. *She stated she looked into the CBU and saw resident 2 and 3 sitting by each other in their wheelchairs in the hallway. *Resident 3 was using hand sanitizer on his hands. *Resident 3 then put his right hand on resident 2's left leg, rubbed her leg, and moved his hand up to her private area between her legs, and then he stopped. -She though resident 3 stopped because he had seen her through the window. *She could not see any staff in the area and went into the CBU and found LPN E at the nurse's station. *She stated a contracted travel CNA was in the dining room when she and LPN E had come back out of the nurses' station. She reported to them what she had seen. *She stated she reported the incident between residents 2 and 3 to DON B on Monday, 6/9/25, when she saw her. 4. Interview on 6/17/25 at 10:30 a.m. with LPN E regarding the above incident revealed: *She had been finishing up things in the CBU nurses' station when housekeeper D reported to her that she thought she saw resident 3 put his hands down resident 2's pants. *She stated she came out of the nurse's station	F 600		

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F 600	Continued From page 5 and CNA J was in the hallway near the dining room. *CNA J had reported that resident 3 had put hand sanitizer on resident 2's hands and she moved resident 2 up to the dayroom. -Resident 3 was down at the end of the hall and then came up the to sit next to resident 2 in the day room. *LPN E stated: -She had been at the nurse's station and had not realized resident 3 was that close to resident 2. -She had documented a progress note of what she was told had occurred from the staff. -When DON B came back to the facility on 6/9/25, she called LPN E in to her office to ask her what had happened on 6/7/25 . -Resident 3 had put sanitizer on resident 2 and the camera footage showed he had put his hand on her knee. -"That is all I saw." -She did not think the 6/7/25 incident was substantial and had not completed an assessment on resident 2 after the incident. She had not completed an incident report, but she documented about it in a progress note. -Stated she had checked resident 2's vital signs the following Monday on 6/9/25 after she had discussed the incident with DON B. 5. Review of resident 3's progress note dated 6/7/25 revealed: *LPN E was the author of that note. *The note indicated, "Housekeeping reported to nurse that she thought she had seen resident put his hands down a females [female's] pants. Writer asked CNA and she stated that what she [had] seen was resident putting hand sanitizer on the females [female's] hands. CNA did intervene and moved resident away from the female	F 600		

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F 600	Continued From page 6 resident. Will continue to monitor for behaviors." *There were no further follow up notes or assessment related to the resident's well-being after that time. 6. Review of resident 3's EMR revealed: *He admitted to the facility on 2/5/22, *His diagnosis included dementia (forgetfulness), altered mental status (confusion), and anxiety. *His quarterly cognitive status dated 6/6/25 indicated: -"Makes Self Understood, Usually understood-difficulty communicating some words or finishing thoughts but is able if prompted or given time." -"Ability To Understand Others, Understands-clear comprehension." *His care plan interventions indicated: - "I need close supervision when I am in common areas around my peers to ensure that I do not harm others or interfere with their with their daily living, which was initiated on 1/28/25." -"Staff to monitor me closely due to my history of being sexually inappropriate with female peers and making socially inappropriate comments to/about female staff, which was initiated on 9/2/25." -"I need staff to monitor me with the females on the unit due to having a history of being inappropriate with them. Examples: Undressing them and getting them into my room, which was initiated on 9/2/24." 7. Review of resident 2's electronic medical record revealed (EMR) revealed: *She was admitted to the facility on 12/15/23. *Her diagnosis included dementia (a group of symptoms affecting memory, thinking and social abilities), anxiety, Psychotic disturbance	F 600		

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F 600	Continued From page 7 (hallucinations, delusions, and disorganized thinking), mood disturbance. *Her quarterly cognitive status dated 5/5/25 indicated: - "Makes Self Understood, Rarely/never understood." -"Ability To Understand Others, Sometime understands-responds adequately to simple, direct communication only." 8. The facility did not have a policy regarding incident reports. Their documentation for "Incident Reporting" for residents was a part of their electronic medical record system referred to as point click care (PCC). The nurses had the option to choose from a drop down menu to complete their documentation which included: -"Med error; Med error Wrong Med." -"Physical Aggression Initiated." -"Physical Aggression Received." -"Alleged Abuse." -"Alleged Neglect." -"Choking." -"Elopement." -"Self-Inflected Injury." -"Pressure Ulcer." -"Injury." -"Fall-Witnessed; Unwitnessed' During staff assist." 9. Review of the "CNA & Nurses Meeting (February 18th, 2025) revealed: *" We met with CNA staff and Nursing Staff to cover this topic." -"Incident/Falls: [resident 3] in CBU is on 1:1. 1 [One] staff member should be within arms length, or in the vicinity of him at all times. He can still visit with and be near his peers, but staff should be able to easily intervene and prevent him from	F 600		

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F 600	Continued From page 8	F 600		

harming others. This does not mean that every time he opens his mouth or goes to visit with someone, we immediately move his wheelchair. When it is time for breaks-as long as there is 1 CNA on the floor for pt care and 1 on the floor for the 1:1 you are ok to [take] breaks. If there are several behaviors going on then you [your] nurse needs to be on the floor with you or you need to have [medical records [(MR)]/[CNA]/medication aide [(MA)]/infection control [(IC)] [K], myself (DON) [B], someone come cover also or you need to wait to take break. We have had 14 state reports in January, 12 of those in the CBU. Nurses should be coming out of the office and assisting in the monitoring halls/dayroom etc."

10. Review of the daily hall sheet used by the staff indicated both resident 2 and 3 were "1:1 within arm length at all times" as explained above.

11. Review of the provider's "Abuse Prohibition" policy dated 3/2024 revealed:
*" The purpose is to establish guidelines to identify and report suspected abuse, neglect or exploitation of disabled adult residents or a resident's inability to care for self. Residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, exploitation, and involuntary seclusion. It is the policy of this facility to protect residents from abuse, regardless of the source, and to have an effective system in place for reporting and investigating incidents. Staff will be available in adequate numbers to insure [ensure] that each shift has sufficient staff to provide care that meets the resident's needs. Staff is responsible to know the resident's care plan they are providing care for."

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F 600	Continued From page 9 *"Definitions of Adult Abuse: ..."Sexual abuse" is non-consensual contact of any type with a resident." *It was the policy of the provider to institute a zero tolerance for any form of abuse to any and all residents. *"Procedure." *"2. Report the incident verbally or in writing to a Charge Nurse or Department Manager. This will initiate investigation of the incident. Clear concise documentation of indisputable evidence is critical for protection of the resident. Document in the resident chart specifics of the investigation, including both the resident and the caregivers' explanation of what occurred. The charge nurse will assess, if immediate medical attention is needed and a preliminary investigation will be completed." *"3. The Administration will complete a thorough investigation of the incident, including interviews with staff, residents and family as appropriate and complete a written report of these findings."	F 600		
F 684 SS=D	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), record	F 684	F 684 System correction: All nursing staff will be re-educated on incident reporting and the requirement for reporting to the State through the Facility-Reported Incidents (FRI) no later than 7/15/25 at the mandatory nurse's meeting. Education will include information from the 2567, a review of new and updated policies including the LTC Abuse Prohibition Policy updated 7/7/25, Incident Reporting and Investigation Policy developed on 7/7/25, State Reporting Policy developed on 7/7/25, along with being re-educated on the one to one (1:1) definition for resident #3. CNAs will be re-educated no later than 7/15/25 on the 1:1 definition for resident #3 and the new Incident Reporting and Investigation Policy and what their part will be in any incident they witness. Continued on next page	07/15/2025

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F 684	Continued From page 10 review, observation, interview, and policy review, the provider failed to complete a resident assessment for the physical and emotional well-being of one of one resident (2) who experienced unsolicited touching of her body by one of one resident (3) following alleged abuse for one of one sampled resident (2). Findings include: 1. Review of the SD FRI report dated 6/9/25 revealed: *The incident occurred on 6/7/25. *Residents 2 and 3 ambulated via wheelchairs independently. *Residents 2 and 3 were in a hallway unmonitored by staff. *Resident 3 propelled himself in his wheelchair up to resident 2 and rubbed her right leg then rolled away from her. *Certified nursing assistant (CNA) J talked to residents 2 and 3 in the hallway but had not separated the residents. *Resident 3 put hand sanitizer on his hands, rolled over to resident 2 and put some of the sanitizer on her hands, started to rub her lap, and touched her private area. *CNA J realized they were next to each other and removed resident 3 from the area and moved resident 2 into the dining room near the table. *The nurse was notified of the situation. *Resident 2's vital signs (measurement of the body's basic functions) were as follows: blood pressure (BP) 153/78, pulse 68, oxygen saturation (level of oxygen in blood) 95 percent on room air. *Resident 2's doctor and family were notified of that incident. *Staff were reminded of the need for resident 3 to be monitored in common areas at all times.	F 684	F684 Continued from previous page A CNA meeting was completed on 7/8/25 that covered the information from the 2567, the 1:1 definition, the new incident investigation form they will be required to fill out if they are a witness to any incident and education on dealing with difficult residents or those with behaviors, ideas on how to re-direct them and examples of interventions. An all staff meeting is scheduled for 7/15/25 to educate staff in all departments on the new Incident Reporting and Investigation Policy with their part in filling out the new incident investigation form if they witness any type of an incident. Information will also be provided to all staff about the 2567. Corrected to individual LPN E: When DON B was notified of incident that occurred on 6/7/25, DON B began investigation into the incident. DON B then submitted a FRI on 6/9/25 since LPN E did not complete an incident report or FRI on 6/7/25. Initial re-education was given to Nurse E about the need for the incident investigation and requirement of the FRI by DON B on 6/9/25 due to LPN E not following proper procedure when employee D reported incident to LPN E. On 06/18/25 LPN E was provided formal education and corrective action by DON B & HR director due to not following proper procedure during/after this incident. LPN E's corrective action was provided later due to issues with schedules. Corrected to individual CNA J: CNA J was from a temp agency and when it was discovered that she had not attempted to prevent the incident on 6/7/25, her company was contacted and she was put on the do not return (DNR) list for our facility on 6/9/25. Corrected to individual resident #3: Re-education was immediately given to nursing staff (nurses & CNAs) working in the unit as soon as the incident was discovered on 6/9/25 about resident #3 needing to be a 1:1 to prevent this type of incident. More formal education to help prevent resident #3 from touching resident #2 or other residents inappropriately is being presented to all nursing staff by 7/15/25 as noted above in system correction. Continued on next page	

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F 684	Continued From page 11 2. Observation and interview on 6/18/25 at 7:46 a.m. of camera footage from 6/7/25 with director of nursing (DON) B revealed: *On 6/7/25 at 10:43 a.m. residents 2 and 3 were in their wheelchairs in the challenging behavior unit (CBU) dayroom. *Resident 2 moved from the hall toward resident 3. *Resident 3 backed up toward resident 2, and rubbed his right hand on her right leg. *There were no staff in the area. *Resident 2 wheeled herself away from resident. *Resident 3 followed her and pushed on the right wheel of resident 2's wheelchair as he continued to follow her down the hallway. *At 10:45 a.m. CNA J came into view from the dining room and then went back into the dining room. -She was not observed intervening or stopping the inappropriate actions between residents 2 and 3. *Resident 2 wheeled herself back up the hall toward resident 3 who was getting hand sanitizer from the wall dispenser. -They had moved toward each other in the hall, but resident 2 then turned and went away away from resident 3. *No staff were seen in that area at that time. *Resident 2 was seen seated in her wheelchair with her right side toward resident 3 who had moved toward her. *Resident 2 then turned and began to move. *CNA J was in the doorway but had not faced them. -CNA J turned back away from the residents and went back into the dining room. *Resident 3 wiped his hands on his shirt. *Resident 2 turned back toward him and stopped	F 684	F 684 Continued from previous page Monitoring of system: DON, Admin or designee will monitor 50% of incident reports to be sure a FRI has been completed if necessary and that it has been initiated in a timely manner. DON, Admin or designee will also monitor the 1:1 for Resident #3 to ensure it is being completed properly. Audits will be completed 2x/wk x 4 weeks, 1x/wk x 4 weeks and monthly x 4 months. Information from all audits will be reported to the QAPI team at monthly QAPI meetings by DON, Admin or designee.	

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herself by resident 3.
*Resident 3 rubbed resident 2's hands, turned toward her, patted and rubbed her hand, and then moved his hand to her private area between her legs.
*At 10:52 a.m. he turned back away and resident 2 and 3 separated as he rolled back up the hallway.
*Resident 2 attempted to go into a room identified as hers by DON B.
*Resident 3 went back toward resident 2 but CNA J took him back toward the dayroom and dining room area.
*Licensed practical nurse (LPN) E did not come in to view on the footage when the above interactions occurred.
*DON B agreed resident 3 had touched resident 2's private area between her legs, without her consent.
*DON B stated LPN E should have completed an assessment on resident 2 for the physical and emotional well-being of her and contacted her.
-She would have expected LPN E to have known to do those things as a nurse.
*DON B explained that the "1:1 within arm reach at all times" regarding residents 2 and 3 that was indicated on the hall sheets was to ensure resident needed close monitoring. Resident 3 would get agitated if staff would get too close to him at times, so staff were to be in close vicinity to intervene."
*DON B was out of the facility on 6/12/25. There had been no further internal investigations completed from Monday 6/9/25 when she had initially become aware of the incident until today 6/18/25.
*DON B thought the staff may have been in the bathroom when not in view on the footage.

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F 684	Continued From page 13 3. Interview on 6/17/25 at 9:25 a.m. with housekeeper D regarding the above 6/7/25 incident revealed: *She had worked the day of 6/7/25 and had been cleaning the nurse's station in the manor unit which adjoined the CBU with double doors with windows when the incident occurred but could not remember the time. *She stated she looked into the CBU and saw resident 2 and 3 sitting by each other in their wheelchairs in the hallway. *Resident 3 was using hand sanitizer on his hands. *Resident 3 then put his right hand on resident 2's left leg, rubbed her leg, and moved his hand up to her private area between her legs, and then he stopped. She though resident 3 stopped because he had seen her through the window. *She could not see any staff and went into the CBU and found LPN E in the nurse's station area. *She stated a contracted travel CNA was in the dining room when she and LPN E had come back out of the nurses' station. She reported to them what she had seen. *She stated she reported the incident between residents 2 and 3 to DON B on Monday, 6/9/25, when she saw her. 4. Interview on 6/17/25 at 10:30 a.m. with LPN E regarding the above incident revealed: *She had been finishing up things in the CBU nurses' station when housekeeper D reported to her that she thought she saw resident 3 put his hands down resident 2's pants. *She stated she came out of the nurse's station and CNA J was in the hallway near the dining room. *CNA J had reported that resident 3 had put hand sanitizer on resident 2's hands and she moved	F 684		

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resident 2 up to the dayroom.
-Resident 3 was down at the end of the hall and came up the hall and was sitting next to resident 2 in the day room.
*LPN E stated she had been in the nurse's station and had not realized resident 3 was that close to resident 2.
*LPN E stated she had documented a progress note of what she was told had occurred from the staff.
*She stated when DON B came back to the facility on 6/9/25, she had asked her what happened on 6/7/25.
*She saw resident 3 had put sanitizer on resident 2 and the camera footage showed he had put his hand on her knee.
-She stated, "That is all I saw."
*She stated she did not think the 6/7/25 incident was substantial and had not completed an assessment on resident 2 after the incident.
*She had not completed an incident report, but she documented about it in a progress note.
*She stated she had checked resident 2's vital signs the following Monday 6/9/25 after she had discussed the incident with DON B.

5. Review of resident 3's progress note dated 6/7/25 revealed:
*LPN E was the author of that note.
*The note indicated, "Housekeeping reported to nurse that she thought she had seen resident put his hands down a females [female's] pants. Writer asked CNA and she stated that what she [had] seen was resident putting hand sanitizer on the females [female's] hands. CNA did intervene and moved resident away from the female resident. Will continue to monitor for behaviors."
*There were no further follow up notes or assessment related to the resident's well-being

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F 684	Continued From page 15 after that time. 6. Review of resident 2's electronic medical record revealed (EMR) revealed: *She was admitted to the facility on 12/15/23. *Her diagnosis included dementia (a group of symptoms affecting memory, thinking and social abilities), anxiety, Psychotic disturbance (hallucinations, delusions, and disorganized thinking), mood disturbance. *Her quarterly cognitive status dated 5/5/25 indicated: - "Makes Self Understood, Rarely/never understood." -"Ability To Understand Others, Sometime understands-responds adequately to simple, direct communication only." 7. Review of resident 3's EMR revealed: *He admitted to the facility on 2/5/22. *His diagnosis included dementia, altered mental status, and anxiety. *His quarterly cognitive status dated 6/6/25 indicated: -"Makes Self Understood, Usually understood-difficulty communicating some words or finishing thoughts but is able if prompted or given time." -"Ability To Understand Others, Understands-clear comprehension." *His care plan indicated the staff were to monitor him closely due to his history of being sexually inappropriate with female peers and making socially inappropriate comments to and about female staff, which was initiated on 9/2/24. -He needed close supervision when he was in common areas around peers to ensure that he did not harm others or interfere with their daily living and which was initiated on 1/28/25.	F 684		

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F 684	Continued From page 16 8. The facility did not have a policy regarding incident reports. Their documentation for "Incident Reporting" for residents was a part of their electronic medical record system referred to as point click care (PCC). The nurses had the option to choose from a drop down menu to complete their documentation which included: -"Med error; Med error Wrong Med." -"Physical Aggression Initiated." -"Physical Aggression Received." -"Alleged Abuse." -"Alleged Neglect." -"Choking." -"Elopement." -"Self-Inflected Injury." -"Pressure Ulcer." -"Injury." -"Fall-Witnessed; Unwitnessed' During staff assist." 9. Review of the "CNA & Nurses Meeting (February 18th, 2025) revealed: *" We met with CNA staff and Nursing Staff to cover this topic." -"Incident/Falls: [resident 3] in CBU is on 1:1. 1 staff member should be within arms length, or in the vicinity of him at all times. He can still visit with and be near his peers, but staff should be able to easily intervene and prevent him from harming others. This does not mean that every time he opens his mouth or goes to visit with someone, we immediately move his wheelchair. When it is time for breaks-as long as there is 1 CNA on the floor for pt care and 1 on the floor for the 1:1 you are ok to [take] breaks. If there are several behaviors going on then you [your] nurse needs to be on the floor with you or you need to have [medical records [(MR)]/[CAN]/medication	F 684		

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aide [(MA)]/infection control [(IC)] [K], myself (DON) [B], someone come cover also or you need to wait to take break. We have had 14 state reports in January, 12 of those in the CBU. Nurses should be coming out of the office and assisting in the monitoring halls/dayroom etc."

10. Review of the daily hall sheet used by the staff indicated both resident 2 and 3 were "1:1 within arm length at all times."

11. Review of the provider's "Abuse Prohibition" policy dated 3/2024 revealed:
*"The purpose is to establish guidelines to identify and report suspected abuse, neglect or exploitation of disabled adult residents or a resident's inability to care for self. Residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, exploitation, and involuntary seclusion. It is the policy of this facility to protect residents from abuse, regardless of the source, and to have an effective system in place for reporting and investigating incidents. Staff will be available in adequate numbers to insure [ensure] that each shift has sufficient staff to provide care that meets the resident's needs. Staff is responsible to know the resident's care plan they are providing care for."
*"Procedure."
*"2. Report the incident verbally or in writing to a Charge Nurse or Department Manager. This will initiate investigation of the incident. Clear concise documentation of indisputable evidence is critical for protection of the resident. Document in the resident chart specifics of the investigation, including both the resident and the caregivers' explanation of what occurred. The charge nurse will assess, if immediate medical attention is

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F 684	Continued From page 18 needed and a preliminary investigation will be completed." *"3. The Administration will complete a thorough investigation of the incident, including interviews with staff, residents and family as appropriate and complete a written report of these findings."	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interviews, record review, and lift manufacturer's instructions, the provider failed to ensure that one of one sampled resident (1) was free from accident hazards during a transfer using a sit-to-stand lift when the manufacturer's operator's instructions for the safe use of the lift had not been followed. Findings include: 1. Review of the provider's FRI submitted to SD DOH on 4/16/25 at 3:42 p.m. revealed: *Resident 1 had a fall from the sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) on 4/9/25 at 5:00 a.m., when his right arm gave out and went above his head during the transfer while using the sit-to-stand	F 689	F 689 System correction: Lifting/Transferring Policy & Fall Policy were updated on 7/7/25. Care Plan Policy was reviewed. All CNAs & nurses will be re-educated on the proper use of the stand-aide lift, updates to the Transfer/ Lift Policy and Fall Policy no later than 7/15/25. CNA meeting was completed on 7/8/25, All Staff meeting and Nurse's meeting are both scheduled for 7/15/25 to be sure all education is completed by 7/15/25. A reference guide and stand-aide lift manual will be placed on all lifts for staff reference as of 7/15/25. Corrected to individual CNA: CNA who was involved in the fall incident was a contracted CNA through a temp agency. After this incident was investigated and due to her involvement, this CNA's contract was terminated and she is now on the DNR list for our facility as of 4/25/25. Corrected to individual resident #1: Prior to this fall, resident #1 had been seen by physical therapy (PT) from 2/26/25 - 3/27/25 for transfer training. Resident #1 then had a cardiac event on 4/6/25 and was admitted to the Heart Hospital until 4/8/25 when he was readmitted to the nursing home. After the fall on 4/9/25, resident was again referred to PT who saw him from 4/13/25 - 6/20/25 to again work on transfers and strengthening. On 5/5/25 PT cleared him to do independent stand pivot transfers to & from wheelchair to toilet and back but needed to continue with using hoyer lift for transfers in & out of bed to wheelchair and for tub transfers. On 6/10/25 PT cleared resident #1 to use the sit to stand lift to & from all surfaces that they were using the hoyer lift for as long as resident #1 agreed to use all straps and buckles. All information on transfers/techniques that were on resident #1's working care plan was updated on the care plan in the EMR on 6/18/25. CNA hall sheets were updated on 6/18/25 with correct transfer/lift techniques that therapy had updated on 6/10/25. Continued on next page	07/15/2025

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F 689	Continued From page 19 and he was lowered to the floor. *The safety straps on the sit-to-stand were not used on his waist or legs during the transfer. *After the fall, he initially complained of feeling sore in both shoulders, which had been baseline for him, but no injury was visualized and he refused medical treatment. *After several days of soreness and refusal of treatment, he agreed to have an x-ray and to see the physician when his pain had not subsided. *The physician found no shoulder dislocation or injury. 2. Interview on 6/17/25 at 9:00 a.m. with resident 1 revealed: *He was well-spoken and easy to understand. *He did not consider the incident on 4/9/25 a fall as he stated his waist belt popped off, and his right arm went above his head, and the staff lowered him to the ground. *He said that both of his arms then went up because his left arm does not work, and it was painful when his left shoulder had pushed into his head. *He denied having refused to wear to the waist or leg straps on the lift, and again stated that the waist belt popped open that day. *He said that the nurse aide, a former employee, always rushed and did not listen to his directions that day. Interview on 6/16/25 at 11:00 a.m. with certified nursing assistant (CNA) F revealed: *Resident 1 would stand and pivot to transfer to and from the toilet during the day. *He only transferred resident 1 with equipment on his bath day, and used a full body lift (a mechanical lift and sling used to lift a person's full body).	F 689	F 689 Continued from previous page Monitoring of System: DON, Admin or designee will monitor staff while using stand-aide lift to ensure proper technique and safety is being used during transfers. DON, Admin or designee will also audit a random sampling of 10 residents' care plans and hall sheets to ensure the transfer levels/techniques for those residents are correct. Audits will be completed 2x/wk x 4 weeks, 1x/wk x 4 weeks and monthly x 4 months	

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F 689	Continued From page 20 *Resident 1 required the use of the Hoyer (full body lift) for a period of time in April 2025 after he fell, but he had been cleared to return to stand and pivot transfers and to use the EZ stand (sit-to-stand) lift. *He had not had issues with resident 1 refusing to use safety straps on equipment during transfers. Interview on 6/17/25 at 1:30 p.m. with CNA G revealed: *Resident 1 was a stand and pivot transfer to and from the toilet. *She did not use a mechanical lift for him as she did not put him to bed or get him up as the night staff did that. Interview on 6/17/25 at 2:00 p.m. with CNA H revealed: *She assisted resident 1 to and from bed regularly. *Resident 1 used the sit-to-stand lift. *He had never refused to use the safety straps when she helped him. *She would get the nurse rather than try to use the equipment without safety straps. *She had not been aware of him refusing to use the safety straps with other staff. Interview on 6/17/25 at 2:00 p.m. with licensed practical nurse (LPN) E revealed: *She had recently been out on leave and did not know how resident 1 was transferred now. *She had been aware that resident 1 had refused to use the safety straps on the mechanical lift prior to her leave. *She asked a CNA how he was to be transferred. 3. Review of resident 1's electronic medical record (EMR) revealed:	F 689		

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F 689	Continued From page 21 *He had a brief interview for mental status assessment (BIMS) score of of 15, which indicated his cognition was intact. *He had no use of his left arm and leg due to a stroke but wore a brace on his left leg that allowed him to bear weight while standing. *A nursing note on 3/28/25 stated that "resident transfers with [the use of an] EZ stand and refused to use chest strap or leg straps. Resident was educated for safety and remains to refuse." *A nursing note on 4/1/25 stated that "resident assisted to bed, transfers with EZ stand. Resident refuses to use chest strap or leg strap. Resident educated on need for straps for safety. Resident transferred per request without safety straps." *Review of the working care plan revealed that resident 1 had been cleared to transfer with a stand and pivot transfer and an EZ stand on 6/10/25. *Review of the hall sheet for daily care revealed that he was to transfer using the Hoyer (full body lift) only. *Review of resident 1's EMR care plan revealed no information about his fall risk, any history of falls, or how he was to be transferred. 4. Interview on 6/17/25 at 2:15 p.m. with Minimum Data Set (MDS) coordinator C revealed: *She agreed that the EMR care plan did not include any information about how resident 1 transferred. *She would not normally put that information in the resident's EMR care plan. *Nursing staff used the working care plan and a hall sheet, which was a pocket care plan, to know how to care for residents.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435100	A. BUILDING _____ B. WING _____	C 06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 22 Interview on 6/17/25 at 3:00 p.m. with administrator A revealed: *After refusing medical treatment for several days after the fall from the lift on 4/9/25, resident 1 agreed to an x-ray and a physician visit, which did not show that he had an injury. *Their internal investigation verified that resident 1 had refused to use the waist belt and knee strap and had only been using the sling at the time of his fall. *She described resident 1 as being very particular with his cares and stated he was known to give staff a very hard time when he felt they were not providing his cares the way he wanted them to. Interview on 6/18/25 at 9:00 a.m. with director of nursing (DON) B revealed: *Resident 1 could be very difficult and demanding, particular about his cares, and had a history of being verbally abusive with staff. *She felt the staff were frustrated with resident 1's refusals to allow the use of the safety straps on his waist and legs when using the mechanical lift, and said they could not force him to use them. *They attempted to limit him to transferring by using the Hoyer lift only, but he refused to use it and said he would stay in bed. *He was cleared by physical therapy to return to stand and pivot transfers and use of the sit-to-stand lift. Review of the EZ Way Smart Stand operator's instructions revealed: "1. Position the harness around the upper body of the patient so the sides of the harness are between the patient's torso and arm, resting 2-3 (two to three) inches below the underarm. 2. For the safety of the patient, securely fasten	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 23 the safety strap around the patient's torso. Use of shin pad strap: If a caregiver deems it necessary to keep a patient's shins or feet on the foot plate, secure the shin strap around the patient's legs."	F 689		