STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435079	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED LIVING COMMUNITY	**405 FIRST AVE , BROOKINGS, South Dakota, 57006**

(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 complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/9/25 through 7/10/25. Areas surveyed included accident hazards related to resident falls and elopement, potential resident-to-resident physical and sexual abuse, and facility-acquired skin wounds. United Living Community was found not in compliance with the following requirements: F658, F689, and F825.	F0000	F0658 - Services Provided Meet Professional Standards. United Living Community (ULC) updated our Falls and Accidents Policy on July 31, 2025. The policy was approved through QAPI on July 31, 2025. Training was created on August 1, 2025, by the Director of Nursing and RN Staff Development and Infection Prevention Specialist. It is a video with the Falls and Accidents Policy, along with a competency quiz at the end. All Nurses will complete this training prior to their next scheduled shift. These changes only apply to Nurses. Updates to the Falls and Accidents Policy include: -Neurological assessment frequency and complete in its entirety -Vitals -Glucose Monitoring -Last Rounded -Last Toileted -Change in Medication -Medication Administered in last 2 Hours -Proper Footwear -Environmental Review -Change in Condition -Diabetic Condition -Removed – Neurological Assessment may be discontinued with Nurse discretion.	8.8.2025
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 the South Dakota Department of Health (SD DOH) complaint intake review, record review, interview, and policy review, the provider failed to adequately monitor for neurological changes and follow the provider's falls protocol for two of three sampled residents (1 and 2) after they had fallen. Findings include: 1. Review of the SD DOH complaint intake received on 4/7/25 revealed: *An anonymous community member called to express their concerns about resident falls at the facility. *Resident 1's falls, which had resulted in "issues," was specifically mentioned with no explanation of what those issues were. 2. Review of resident 1's electronic medical record (EMR) revealed:	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	(X6) DATE
Liz Mosena DeBerg	LNHA	8.8.2025

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F0658 SS = E	Continued from page 1 *Her 6/10/25 Brief Interview for Mental Status (BIMS) assessment score was 5, which indicated she had severe cognitive impairment. *Her diagnoses included Parkinson's Disease, dementia, anxiety, muscle weakness, repeated falls, hypertension, chronic pain, and wandering. -Parkinson's Disease affects brain cells, causing movement and balance problems. -Dementia causes memory loss and confusion, affecting daily life activities. -Anxiety makes a person feel worried or scared about things often. -Muscle weakness means a person's muscles are too weak to work well. -Repeated falls means falling often without a clear reason. -Hypertension is high blood pressure. -Chronic pain means the person experiences long-lasting pain that does not go away easily. -Wandering is when a person becomes lost or moves around without purpose. *Her care plan interventions included: -She needed the assistance of one staff member for transfers and supervision/touching assistance with her walker, staff assisted her as needed, and used a wheelchair as needed. -She refused to use her walker at times. *She fell, unwitnessed, on 1/25/25. -Her neurological evaluation (an assessment of nerve function, reflexes, coordination, motor skills, sensation, reflexes, and mental status) (neuro eval) was not fully completed. --Staff failed to assess her level of consciousness (LOC), pupil response, motor functions, pain, and temperature at 5:30 p.m. Staff also did not assess her LOC, pupil response, motor function, and pain response at 6:30 p.m.	F0658	Continued from page 1... The Fall Risk Management, Fall Risk Assessment, and Managing Falls and Fall Risks were combined into one Falls and Accidents Policy. All falls, witnessed, not witnessed, and falls with injury are treated the same. Clinical Stand-Up Team includes, but is not limited to the Director of Nursing, Social Worker, RN Staff Development and Infection Preventionist, Case Manager/MDS Coordinator x2, Director of Environmental Services, and Administrator. -The Clinical Stand-Up Team meets each business day. -The Clinical Stand-Up Team reviews all falls; completes a root cause analysis, update fall interventions in the Care Plan and Family Sheet and remove any interventions that no longer apply. -The Clinical Stand-Up Team will audit weekly to ensure preventative interventions are completed, and the post fall procedure is completed in its entirety, when applicable for each fall. -Audits to occur weekly x4 weeks and monthly x2 months. Results of the audits will be brought forward to the Quality Assurance and Performance Improvement Committee to analyze data and determine if further change is necessary or to discontinue audits.	

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F0658 SS = E	Continued from page 2 *She fell, unwitnessed, on 1/28/25. -Her neuro eval was not fully completed. --Staff failed to assess her pupil response, motor function, pain response, and vital signs at 5:55 p.m. A note stated, “getting ready for bed/BR [bathroom].” Between 6:10 p.m. and 8:25 p.m. her LOC, pupil response, motor functions, and pain response was not completed. At 9:25 p.m. and 10:25 p.m. her LOC, pupil response, motor functions, and pain response were not completed, and the nurse did not initial the assessments. -Her blood sugar was not measured as part of the falls protocol (assessment and follow-up processes after a resident falls). *She fell, unwitnessed, on 2/1/25. -Her neuro eval was not fully completed. --At 11:15 a.m. staff did not assess the pupil response, motor functions, pain response, or vital signs. A note stated, “eating lunch-no issues noted.” -Her blood sugar was not measured as part of the falls protocol. *She fell, unwitnessed, 2/17/25 and sustained a bump to the side of her head. -Her neuro evaluation was not fully completed. --The staff failed to assess the pupil response and obtain vital signs between 2:00 p.m. and 3:45 p.m. Staff did not assess her LOC, pupil response, motor functions, pain response, or vital signs at 7:00 p.m. -Her blood sugar was not measured as part of the falls protocol. *She fell, witnessed, on 3/18/25. -Her blood sugar was not measured as part of the falls protocol. *She fell, unwitnessed, on 4/1/25. -Her neuro evaluation was not fully completed. --The staff did not initial the completed assessments between 7:30 p.m. and 8:00 p.m. On 4/2/25 at 1:00 a.m., her LOC, pupil response, motor functions, and pain	F0658	Continued from page 2... The Post Fall Procedure includes 1. Ensure the area is safe 2. Assess level of consciousness (LOC) and their airway, breathing, circulation (ABC’s), and neurological checks. a. Assessment for head injury must include vital signs and neurological assessments at least every 15 minutes x4, every 30 minutes x2, every hour x4, and every 4 hours x4. 3. Treat immediate/emergent injury and need for transportation to the emergency department. 4. Obtain full set of vitals 5. Obtain full blood glucose reading. 6. Complete head to toe assessment. Observe for injury and or pain, limited range of motion, and disability. 7. Determine if it is safe to move the resident. 8. Assess the reason for the fall: a. Last time rounded b. Last time toileted c. Change in medication d. Medication administered in the last 2 hours e. Footwear f. Environment g. Recent change in condition 9. Treat injuries 10. Provide emotional support 11. Remove/repair the fall risk 12. Notify a. Family b. eCare c. Emergency Department/911 d. Hospice e. Primary Care Physician f. Administrator, Director of Nursing, or designee – if fall results in an injury or death. Notification needs to be done within 2 hours.	

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F0658 SS = E	Continued from page 3 response were not assessed. At 2:00 a.m., her LOC, pupil response, motor functions, pain, and vital signs were not assessed. At 6:00 a.m. her LOC, pupil response, motor functions, and pain response were not assessed. -Her blood sugar was not measured as part of the falls protocol. *She fell, unwitnessed, on 5/25/25. -Her evaluation was not fully completed. --Staff failed to assess her LOC, pupil response, motor functions, and pain response from 6:50 p.m. to 9:20 p.m., and from 10:20 p.m. to 5:20 a.m. on 5/26/25. -Her blood sugar was not measured as part of the falls protocol. *She fell, witnessed, in her bathroom on 6/22/25. -Her blood sugar was not measured as part of the falls protocol. *She fell, unwitnessed, on 7/6/25 in her bathroom. -Her neurological evaluation was not fully completed. --Staff failed to initial the completed assessments at 9:05 a.m., 9:20 a.m., 12:50 p.m., 1:50 p.m., and 3:50 p.m. Staff failed to assess pain, vital signs, and initial the assessment at 11:20 a.m. -Her blood sugar was not measured as part of the falls protocol. 3. Review of resident 2's EMR revealed: *Her 6/18/25 BIMS assessment score was 3, which indicated she had severe cognitive impairment. *Her diagnoses included unspecified dementia, dysuria, chronic kidney disease stage 3, and type 2 diabetes mellitus. -Dysuria means pain with urination. -Chronic kidney disease stage 3 means a person's kidneys are working at half the capacity. -Type 2 diabetes mellitus means a person's blood sugar cannot be controlled well by insulin.	F0658		

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F0658 SS = E	Continued from page 4 *She fell, unwitnessed, on 2/8/25. -Her neuro eval was not fully completed. --Staff did not document the assessment of the resident's LOC, pupil response, motor functions, or pain response from 8:30 p.m. on 2/8/25 until 5:30 a.m. on 2/9/25. Staff also did not obtain a set of vitals at 10:30 p.m. and 11:30 p.m., noting that resident 2 was sleeping. -Her blood sugar was not measured as part of the falls protocol. *She fell, unwitnessed, on 2/28/25. -Her neuro eval for the unwitnessed fall on 2/28/25 was not fully completed. --At 10:55 p.m., 11:55 p.m., 12:55 a.m. on 3/1/25, and 1:55 a.m. on 3/1/25, her LOC, pupil response, motor functions, pain response, and vitals were not obtained, noting that she was sleeping. *She fell, witnessed, on 3/10/25 and sustained an injury to her face. -Her neuro eval after she fell on 3/10/25 was not fully completed after the resident returned from the emergency room. --The discharge paperwork from the emergency room indicated that she sustained a contusion (a bruise) to her face. -Her blood sugar was not measured as part of the falls protocol. *She fell while she was out with her family on 4/9/25. -There was no documented neuro eval, post-fall assessment, or communication with resident 2's primary care provider related to her having fallen on 4/9/25. *She fell, unwitnessed, on 5/24/25. -Her neuro eval for the unwitnessed fall on 5/24/25 was not fully completed. --From 11:45 p.m. on 5/24/25 to 6:15 a.m. on 5/25/25, her LOC, pupil response, and motor functions were not assessed.	F0658		

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F0658 SS = E	Continued from page 5 --Her vitals were not obtained at 3:15 a.m., 5:15 a.m., and 6:15 a.m. on 5/25/25. -Her blood sugar was not measured as part of the falls protocol. 4. Interview on 7/9/25 at 3:39 p.m. with licensed practical nurse (LPN) E revealed: *They started neuro checks on residents who had unwitnessed falls whether the resident hit their head or not. *Blood sugar levels were to be measured for each resident after they fell. *The neuro checks were to be performed every 15 minutes for one hour, every 30 minutes for two hours, every hour for four hours, (but after two checks during those four hours, it was at the nurse's discretion to discontinue the neuro checks or not), and then every four hours for four times, if not discontinued by the nurse before that. *She would only discontinue the neuro checks on a resident if it was "really obvious" that the resident had not hit their head, such as, if the resident said they did not hit their head and there were no bumps or bruises. -She would write the reasons why the neuro checks were discontinued on the resident's neuro check sheet. *The neuro check sheets were to be filled out completely. *She indicated that the nurses sometimes struggled to complete the neuro check sheets depending on the care needs of other residents. 5. Interview on 7/9/25 at 4:39 p.m. with the director of nursing (DON) B revealed: *After a resident fell, she expected the nurses to start neuro checks immediately, assess the resident for injuries, and obtain the resident's vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate). *She expected neuro checks to be completed and documented every 15 minutes for one hour, every 30	F0658		

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F0658 SS = E	Continued from page 6 minutes for two hours, every hour for four hours, and then every four hours for 16 hours. -She expected the neuro check sheets to be filled out completely. -If the resident refused to have their neuros checked or vitals taken, she expected the nurse to document those refusals on the neuro check sheet. -All fall reports and neuro check sheets were to be given to her for her to review, and then they were to be scanned into the resident's chart. *She confirmed the neuro check sheets for residents 1 and 2 were not filled out completely, as described above. *The falls policy was scheduled to have been reviewed, updated, and approved at their next quality assurance and performance improvement meeting, originally scheduled for 7/10/25 which had to be rescheduled due to the survey. -They had been using the falls protocol check sheet as their falls policy prior to the development of that new policy. 6. Review of the provider's undated "FALLS, WHAT TO DO IN THE EVENT OF A FALL" document revealed: *"All Falls - Witnessed or Not Witnessed -…5. Orthostatic Vital Signs (first lying, before getting [the] resident up.) Chart if unable or inappropriate for the situation. -…7. Full set of vitals (blood pressure, pulse, respirations, temp, O2 sat). -8. Get [the resident's] blood sugar reading. -9. Assess the reason for [the] fall. Things that will need to be in the fall report: --a. Last time rounded [checking on residents' status and assistance needs] --b. Last time toileted [assisted with bathroom needs] --c. Change in medication --d. Medication[s] administered in the last 2 hours	F0658		

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F0658 SS = E	Continued from page 7 ---i. PT/INR [prothrombin time/international normalized ratio] --e. What was on residents' feet i.e. socks, grip socks, shoes, barefoot --f. Environment [conditions] --g. Recent changes in resident condition --h. Diabetic conditions…" *"…Witnessed with NO head injury-may exclude neurological checks/flow sheet." *"Neurological checks/Flow Sheet -All unwitnessed falls and witnessed falls with Head Injury. -Must be initiated for 24 hours and documented. -Time frame: every 15 min x 4 [four times], every 30 min x 4, every hour x 4, every 4 hours x 4. -Nurses will be permitted to vary the neuro assessment time frames slightly due to other resident needs or schedules. -Neuro checks may be discontinued at the nurse's discretion after two 60 min [minute] checks have been completed and the resident appears to be stable. -Follow up with [the] physician as appropriate or indicated."	F0658		
F0689 SS = G	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:	F0689		

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F0689 SS = G	Continued from page 8 Based on the South Dakota Department of Health (SD DOH) complaint intake review, interview, observation, record review, and policy review, the provider failed to communicate with staff and implement fall prevention interventions, which potentially contributed to at least six falls (four of which resulted in injuries) from 2/1/25 to 7/6/25 for one of two sampled residents (1). Findings include: 1. Review of the SD DOH complaint intake received on 4/7/25 revealed: *An anonymous community member called to express their concerns about resident falls at the facility. *They specifically mentioned resident 1's falls which had resulted in "issues." -They did not explain what those issues were. 2. Review of resident 1's electronic medical record (EMR) revealed: *Her 6/10/25 Brief Interview for Mental Status (BIMS) assessment score was 5, which indicated had severe cognitive impairment. *Her diagnoses included Parkinson's disease, dementia, anxiety, muscle weakness, repeated falls, hypertension, chronic pain, and wandering. -Parkinson's disease affects brain cells, causing movement and balance problems. -Dementia causes memory loss and confusion, affecting daily life activities. -Anxiety makes a person feel worried or scared about things often. -Muscle weakness means a person's muscles are too weak to work well. -Repeated falls means falling often without a clear reason. -Hypertension is high blood pressure. -Chronic pain means the person experiences long-lasting pain that does not go away easily.	F0689	F0689 - Free of Accident Hazards/ Supervision Devices Directed In-Service: F689: Administrator, DON, and interdisciplinary team in collaboration with the medical director, to review, revise, create as necessary policy and procedure to identify resident(s) at risk for falls and effectively implement interventions to minimize as much as possible potential for injury for individual(s). Do look at individual preferences/likes-dislikes for distractions. Brainstorm as a team about the individual who is a frequent faller. Provide education and training to all staff ab out their roles and responsibilities for acer for those at risk for falls and those who have fallen frequently. Comprehensive Care Plans -All residents who incurred a fall with injury in the past rolling calendar year, were reviewed and updated by the Clinical Stand-Up team. -All resident care plans were reviewed for accuracy and person-centered practices by the Clinical Stand-Up Team. -All CNA's have access to the Kardex, within PointClickCare, for all focus areas, goals and interventions/tasks that pertain to their scope of practice. This was completed by the Clinical Stand-Up Team. -Training was created by the Director of Nursing and RN Staff Development and Infection Prevention Specialist. It is a video with how to access the Kardex in PointClickCare and what the expectation is for knowing and documenting, along with a competency quiz at the end. -This allows for all CNA's to have access to Care Plans and in real time updates.	8.8.2025

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F0689 SS = G	Continued from page 9 -Wandering is when a person becomes lost or moves around without purpose. *She fell on 2/1/25 in the dining room when staff had briefly left her alone. *She fell on 2/8/25 in the dining room and sustained a “tiny” skin tear on her left hand. *She fell on 2/17/25 in the dining room and sustained a bump to the side of her head. *She had fallen on 4/1/25 at around 7:13 p.m. in the hallway and was found lying face down and sustained a laceration (cut or torn skin) on her cheek. -She went to the emergency room for evaluation. -Per the 4/1/25 fall report, staff were to assist her with using the toilet her every two hours. The last time she was assisted to the bathroom was at 4:30 p.m., which was 2 hours and 43 minutes before fall. Staff were to also monitor her closely when she was out of her room. *She fell in her bathroom on 6/22/25 after a CNA left her alone to grab supplies. As the CNA was re-entering the bathroom, resident 1 attempted to stand up and fell. *She fell on 7/6/25 in her bathroom after a CNA left her alone to grab supplies. -Per her care plan, she was not supposed to be left alone. -She sustained a bump to the back of her head and a skin tear to her right elbow that required Steri-Strips [adhesive strips used to close a wound]. 3. Interview on 7/9/25 at 10:13 a.m. with certified nursing assistance (CNA) N revealed: *Resident 1 had fallen before, but she could not remember if she had fallen recently. *A few months prior, resident 1 had fallen and received a bruise to her face. *The care plan (a personalized plan that addresses a resident’s care needs, goals, and interventions) binder was not up to date, as it contained care plans for	F0689	Continued from page 9... The RN Staff Development and Infection Prevention Specialist or designee will monitor completion of training and report in QAPI to ensure 100% compliance. -The CNA onboarding training checklist was updated by our RN Staff Development and Infection Prevention Specialist to include how to access the Kardex. -Care Plans will be reviewed by the Clinical Stand-Up Team a minimum of quarterly, prior to each resident’s MDS or Change in Condition. -Care Plans that were reviewed will be audited by the Director of Nursing or designee and reviewed a minimum of quarterly in QAPI. -Care Plans will be reviewed for 100% accuracy and will continue through the 2026 annual survey review. Family Sheets -All family sheets are updated and accurate. These were updated by the Director of Nursing and RN Staff Development and Infection Preventative Specialist. -Family sheets have been broken down into “families” so staff know what residents they are responsible for on their shift and get familiar with health, safety, care, and welfare needs for each resident. Family sheets include: --Resident Name --Resident Room# --Resident Code Status --Diet / Blood Sugar --Incontinence Products --ADL’s/Seating, Wanderguard/VST/ Special or Adaptive Equipment	

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F0689 SS = G	Continued from page 10 residents who had since passed away or moved to other halls. *Sometimes there were pocket care plans (a document that identifies residents' care needs and interventions) inside the resident's closet or cabinet in their rooms. *She indicated the lead CNAs would help with updating the resident pocket care plans. 4. Observation on 7/9/25 at 10:42 a.m. of resident 1's room revealed: *There was a sign on the outside of the bathroom door and above the toilet that stated, "Please do not leave me unattended while I am using the bathroom." *There was no pocket care plan inside her closet or cabinet doors. 5. Interview on 7/9/25 at 3:00 p.m. with CNA I revealed: *Resident 1 had a diagnosis of Parkinson's disease. *A therapy wedge pillow block was placed by resident 1's right side when she was lying in bed to help her identify where the edge of the bed was. The wedge also helped her legs from flailing around due to her Parkinson's disease. *She stated that resident 1 was "the biggest fall risk in the building." *Resident 1 was in a wheelchair for a while after she had fallen, as she was scared of falling. CNA I indicated that resident 1 was also scared to sit on the toilet. *Staff were supposed to always keep resident 1 within their eyesight and were to chart about her whereabouts every two hours in the EMR. -Resident 1 required 24/7 [24 hours a day, 7 days a week] supervision. *Resident 1 was not allowed to be in the bathroom by herself, and that staff were to remain in the bathroom with her.	F0689	Continued from page 10... --Miscellaneous – Dentures, Hearing Aids, Glasses etc. --Last Time Toileted --Things to note/report to Nurse -Family sheets are located within each neighborhood. -Family sheets will be audited a minimum of quarterly by the Director of Nursing or designee to ensure accuracy at 100%. -This data will be collected and aggregated in QAPI a minimum of quarterly.	

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F0689 SS = G	Continued from page 11 6. Interview on 7/9/25 at 3:15 p.m. with unlicensed assistive personnel (UAP) G revealed: *Resident 1 was impulsive, would stand up from her chair quickly, and often tripped over her shoes. *Resident 1 was not included in the pocket care plan binder, but she was included on the “family sheet” located in a different binder. -The family sheets included a list of residents on that unit and their special care needs, such as their diet order, code status, what size of incontinence products to use, and how the resident transferred. 7. Review of the undated “SUNSHINE [the secured memory care unit] FAMILY 1” sheet regarding resident 1 revealed: *She needed one staff member to assist her with transfers and required the use of a walker. *“Special equipment” included a VST (a motion-detection device that alerted staff of a resident’s movement), and a WanderGuard (a wearable door-alarming device). *“Hip pads under her pants” was included in the miscellaneous section. *It also included her code status, diet order, the size of her incontinence products, and that she wore glasses. *No other safety interventions were included. 8. Interview on 7/9/25 at 3:39 p.m. with licensed practical nurse (LPN) E revealed: *Family sheets should have included the residents’ fall prevention interventions. *Family sheets were updated by director of nursing (DON) B. *The CNAs wrote notes and updates on the family sheets and turned them in to DON B to update the family sheets. 9. Interview on 7/10/25 at 8:14 a.m. with LPN F revealed:	F0689		

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F0689 SS = G	Continued from page 12 *Resident 1 was very impulsive. She had a hard time understanding directions, as she would usually do the opposite of what was asked of her. -She frequently fidgeted and had tremors (involuntary shaking movements) due to her Parkinson's disease. *Staff tried to engage her with meaningful activities like folding laundry and coloring. *Resident 1 ambulated with staff using a four-wheeled walker. -Staff used a gait belt (a waist strap gripped as support for safe mobility and transfers) around her waist for stability and to remind her to slow down. *Resident 1 walked with a shuffled gait and normally wore tennis shoes. 10. Continued interview with LPN F and review of resident 1's care plan revealed fall-prevention interventions that included: *"Follow signage, I will not be left alone in bathroom." That was created on 6/24/25 and revised on 7/7/25. *"I will not be left alone in public areas." That was created on 6/24/25. *" Ensure that [the] resident is wearing appropriate footwear nonskid shoes/socks when out of bed." That was created on 2/18/25 and revised on 3/10/25. *"PT [physical therapy] and OT [occupational therapy] [to] evaluate and treat as ordered or PRN [as needed]." That was created on 11/18/22 and revised on 6/19/24. *"Sign on walker to remind to use." That was created on 7/24/24. *"I will not be put to bed before 1900 [7:00 p.m.]." That was created on 6/24/25. *"10/30/24: Poor gait balance awareness." *"Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers:" That was created on 12/11/22. -The care plan was not personalized to indicate what	F0689		

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F0689 SS = G	Continued from page 13 type of pleasant diversions the resident prefers. *"AMBULATION: Resident['s] usual [performance] consists of supervision/touching assist [assistance] with walker; staff assists as needed. Resident may refuse her walker at times; staff assists as needed." That was created on 11/19/22 and revised on 7/9/25. *"DRESSING: …Hip pads [extra padding to provide cushion] to hips per family request; staff assists as needed." That was created on 11/18/22 and revised on 7/9/25. *Her care plan included several restorative therapy interventions. LPN F indicated that resident 1 did not participate in the restorative therapy program. 11. Interview on 7/10/25 at 8:40 a.m. with CNA K revealed the "family sheets" included that resident 1 was supposed to use hip pads. There were no fall interventions for resident 1 on the "family sheets." 12. Observation on 7/10/25 at 8:48 a.m. of resident 1 in the dining room revealed: *She was coloring a picture while seated at a dining room table. *Her feet and her head were tremoring. *She was wearing sneakers. *Resident 1's spouse, who also resided in the memory care unit, was sitting on resident 1's four-wheeled walker and propelling himself in the dining room. *There was no sign on her walker to remind resident 1 to use her walker. 13. Interview on 7/10/25 at 8:58 a.m. with CNA J revealed that resident 1 had a restorative program but had not participated in it for a while, and that it stopped a few months ago after resident 1 fell. 14. Interview on 7/10/25 at 9:59 a.m. with physical therapy assistant H revealed that resident 1 had not been assessed by PT/OT since 6/19/24. 15. Interview on 7/10/25 at 10:12 a.m. with CNA J	F0689		

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F0689 SS = G	Continued from page 14 revealed: *She confirmed resident 1 did not have a sign on her walker to remind her to use it. *The pocket care plans in the care plan binder were not up to date. -The pocket care plans in the binder included several residents that were no longer residing on that unit and was missing seven current residents. *She would have expected to find the residents' fall interventions listed on the pocket care plans or family sheets. -She confirmed that the family sheets did not include resident 1's fall interventions. *She stated that she usually would not look in the provider's EMR for fall interventions. *CNA J was only able to pull up and view the first page of resident 1's 28-page care plan in the EMR. 16. Interview on 7/10/25 at 12:54 p.m. with case managers C and D revealed: *Resident 1 was very impulsive, and did not always voice her needs or wants. *Resident 1 spent a lot of time in the common areas and staff tried to always be present in those areas. *Resident 1's walker was supposed to have been kept within reach with the brakes on. *Resident 1's gait was shuffled, and she tripped over her feet, so they tried to always have someone near her. -Her care plan included interventions such as "I will not be left alone in bathroom" and "I will not be left alone in public areas." *Case manager C was not aware that resident 1 used a blue wedge for positioning and expected that to have been included on the resident's care plan. *She indicated that "a lot of people are responsible for updating the care plan." *Both case managers C and D were new to their	F0689		

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F0689 SS = G	Continued from page 15 positions, and they were learning what to include on the residents' care plans. *The facility transitioned to using the family sheets in March 2025 rather than the pocket care plans. -Several people were responsible for updating the family sheets, including the DON, the case managers, and the lead CNAs. *They were not sure what the expectation was for CNAs to have access to the residents' care plans. 17. Interview on 7/10/25 at 2:05 p.m. with DON B revealed: *Resident 1 had a decline in her cognition with her dementia. *She confirmed the resident's sign to remind her to use her walker was not on her walker. *Pocket care plans were no longer to be used. Staff were to use the family sheets for resident care information. -Family sheets were to be updated when a new resident was admitted, and as needed with pertinent resident care information. *CNAs could not access the resident care plans in the EMR. -CNAs were to use the family sheets to understand how to care for the residents. *They also utilized shift-to-shift report to update staff on new resident information. *The family sheets included resident care information, such as the resident's diet, how they ambulate, how they transfer, if they wear hearing aids or dentures, their code status, what they prefer in their room, and if they were on enhanced barrier precautions. *She hung a sign on resident 1's bathroom door on 7/7/25, after the resident was left alone in the bathroom again and fell, to remind staff that resident 1 should not be left alone while in the bathroom. 18. Review of the providers 4/11/24 "Falls and Fall Risk, Managing" policy revealed:	F0689		

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F0689 SS = G	Continued from page 16 *"Definition *…Fall Risk Factors -1. Environmental -a. wet floors -b. poor lighting …f. footwear that is unsafe or absent. -2. Resident conditions that may contribute to the risk of falls include: -a. fever -…d. pain -e. lower extremity weakness -…k. incontinence -3. Medical factors that contribute to the risk of falls include: -…e. balance and gait disorders; etc." *"Resident-Centered Approaches to Managing Falls and Fall Risk -1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. -2. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. -3. Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lighting, etc. -…6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified and unavoidable.	F0689		

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F0689 SS = G	Continued from page 17 -7. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. -8. Position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner." *"Monitoring Subsequent Falls and Fall Risk -1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. -2. If interventions have been successful in preventing falls, staff will continue the interventions…. -3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. -4. The staff and/or physician will document the basis for conclusion that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls." Review of the providers 4/11/24 "Care Planning-Interdisciplinary Team" policy revealed: *"Policy Statement: Our facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident." *"Policy Interpretation and Implementation -…2. The care plan is based on the resident's comprehensive assessment and is developed by a care planning/interdisciplinary team which includes, but is not necessarily limited to the following personnel: --a. The residents' attending physician; --b. The registered nurse who has responsibility for the resident;	F0689		

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F0689 SS = G	Continued from page 18 --…f. Therapists (speech, occupational, recreational, etc.), as applicable; --…h. The director of nursing (as applicable); --i. The charge nurse responsible for the resident's care; --j. Nursing assistants responsible for the resident's care…"	F0689	F0825 – Provide/Obtain Specialized Rehab Services United Living Community (ULC) offers Restorative Therapy, to any resident that would benefit, and would like to participate. Residents will be identified as a possible candidate for Restorative Therapy based on the following criteria: - Decline in physical, mental, and psychosocial functioning, not in alignment with the resident's individual goals - Decline in ability to complete activities of daily living unless circumstances of the resident's clinical condition demonstrates that diminution was unavoidable. ADLs are defined as bathing, dressing, grooming, transfers, ambulation, toileting, eating, speech, language or other functional communication system. Residents identified that will participate in Restorative Therapy will have a Care Plan that explains the program. -Each resident who is on a restorative therapy plan will be reviewed in QAPI a minimum of quarterly to ensure the Care Plan matches the services being provided. Restorative Therapy Manual to implement our program. -Data that will be collected is restorative therapy documentation, goals, falls, and ADL's. This data will be collected monthly and audited by the Director of Nursing or designee.	8.8.2025
F0825 SS = D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider failed to implement and effectively manage a nursing restorative therapy program for one of one sampled resident (1). Findings include: 1. Review of the SD DOH complaint intake received on 4/7/25 revealed: *An anonymous community member called to express their concerns about resident falls at the facility.	F0825		

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F0825 SS = D	Continued from page 19 *They specifically mentioned resident 1's falls, which had resulted in "issues." -They did not explain what those issues were. 2. Review of resident 1's care plan revealed: *A focus area that read, "I am in need of restorative therapy to maintain my functions and abilities." Created on 6/25/24. *Interventions that included restorative programming included: -"NURSING REHAB/RESTORATIVE: Transfer Program #1 : Nu-step at level 5 for up to 15 minutes up to [6 to 7] days a week." Created on 6/25/24. -"NURSING REHAB/RESTORATIVE: Transfer Program #1 : Nu-step at level 5 for up to 15 minutes up to [6 to 7] days a week. Goal to maintain ability [and] strength to remain free of fall with a major injury." Created on 2/25/24. Revised on 2/25/24. -"NURSING REHAB/RESTORATIVE: PASSIVE ROM [range of motion] Program #1 Static stretching with 30 second holds to upper and lower extremities for 15 minutes up to [6 to 7] days a week. Goal to prevent contractures [and] remain comfortable." Created on 2/25/24. Revised on 2/25/24. -"Restorative program for balance and lower extremity strengthening." Created on 12/4/24. 3. Review of resident 1's electronic medical record (EMR) revealed: *One of the items on the "tasks" page for certified nursing assistants (CNAs) to chart on included "Restorative Nursing-RESTORATIVE: Transfer Program #1 : Nu-step at level 5 for up to 15 minutes up to [6 to 7] days a week." -In the 30-day lookback report, the response was charted as "Not Applicable" on 7/6/25, "Resident Not Available" on 7/7/25, and "0" in the "Amount" column on 7/9/25.	F0825	Continued from page 19... In addition, the Interdisciplinary Team will examine the effectiveness of the therapy plan, to see if falls have been reduced. If not, explore new interventions. - The Care Plan should match the services at 100% through the 2026 annual survey review.	8.8.2025

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F0825 SS = D	Continued from page 20 *Her diagnoses included chronic pain, low back pain, neurocognitive disorder with Lewy bodies, muscle weakness, unsteadiness on feet, anxiety disorder, dementia, and Parkinson's disease with dyskinesia (involuntary, uncontrolled muscle movements often caused by neurological disorders). -Chronic pain means the person experiences long-lasting pain that does not go away easily. -Neurocognitive disorder with Lewy bodies is a brain disorder causing memory loss, hallucinations, and movement problems. -Muscle weakness means a person's muscles are too weak to work well. -Unsteadiness on feet means trouble standing or walking without losing balance. -Anxiety disorder makes a person feel worried or scared about things often. -Dementia causes memory loss and confusion, affecting daily life activities. 4. Interview on 7/10/25 at 9:00 a.m. with CNA J revealed: *There were two restorative CNAs in the therapy department. *She believed that resident 1 was the only resident on the memory care unit that had a restorative program. -Resident 1 had not participated in the restorative therapy program for several months. *She explained that resident 1 had a fall with injury, and the restorative program would probably restart after she was more stabilized. -She did not explain when resident 1 had that fall, or what type of injury the resident sustained. 5. Interview on 7/10/25 at 9:59 a.m. with physical therapy assistant (PTA) H revealed: *She confirmed that resident 1 was not currently receiving skilled therapies.	F0825		

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F0825 SS = D	Continued from page 21 *The last time resident 1 was discharged from skilled therapies was on 6/19/24. 6. Interview on 7/10/25 at 11:37 a.m. with CNA L revealed: *She was one of the restorative CNAs and had been working at the facility for nine years. -She had been the only restorative CNA for the past three to four years. *A second restorative CNA was recently hired, and she helped train them on restorative programming. *She confirmed resident 1 had a restorative program in place. -Resident 1 would refuse to participate in the programming. *She confirmed she was supposed to chart that the resident had refused, but she had not been doing that. *She explained, “when I was by myself, I focused on the other people who would be more willing to do the program.” *It had been several months since resident 1 last participated in the restorative program. *She would often get pulled from the restorative therapy program as she was reassigned to fill in for other CNAs that called out. *There were about 25 residents with a custom restorative therapy program. -She could not handle that caseload by herself, which is why a second restorative aide was hired. *She confirmed that director of nursing (DON) B oversaw the restorative therapy program. *The restorative program got “pushed to the side” because she was getting pulled to work the nursing floor often. 7. Interview on 7/10/25 at 12:53 p.m. with case managers C and D revealed: *They denied that the restorative program was “pushed	F0825		

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F0825 SS = D	Continued from page 22 to the side," explaining that it was hard to keep up with because they had one restorative aide conducting the program. They hired a second restorative aide to help with the caseload. *They confirmed that DON B managed the restorative therapy program. *They expected the restorative aides to chart each time a resident refused or participated in the restorative program. 8. Interview on 7/10/25 at 2:05 p.m. with DON B revealed: *She confirmed that resident 1 was supposed to have a restorative therapy program. *She had identified "a problem" with their restorative therapy program. -Restorative therapy was not being captured on the Minimum Data Set as it should have been. -The restorative program was not fully implemented as the case load was too large for one restorative aide to handle. -Resident refusals were not documented consistently. *They recently had a meeting between the nursing managers and the restorative aides to discuss improvements. *The physical and occupational therapists helped develop a resident's restorative therapy program. *She confirmed that CNA L "has been getting pulled to the floor." *She confirmed that she took over managing the restorative therapy program in March 2025 since the previous program manager had left. *They were hoping the restorative therapy program would improve with the hiring of a second restorative aide. 9. Surveyors requested the restorative therapy program policy from administrator A on 7/10/25 at around 4:07 p.m. Administrator A explained that the program booklet was a large document and did not know which part to print. Surveyors asked if the program booklet could be	F0825		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435079	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED LIVING COMMUNITY	**405 FIRST AVE , BROOKINGS, South Dakota, 57006**

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F0825 SS = D	Continued from page 23 sent via email and administrator A agreed. Surveyors requested for the program booklet to be emailed by 5:00 p.m. on 7/11/25. The program booklet was not received by the survey team by 5:00 p.m. on 7/11/25.	F0825		