| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435078 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 06/11/2026 |
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| **Avera Eureka Health Care Center** | **202 J AVENUE POST OFFICE BOX 40, EUREKA, South Dakota, 57437** |

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| F0000 | INITIAL COMMENTS<br><br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/9/26 through 6/11/26. Avera Eureka Health Care Center was found not in compliance with the following requirements: F578, F700, and F812.<br><br>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/9/26 through 6/11/26. The areas surveyed were quality of care related to resident neglect, a resident's personal hygiene, resident's room cleaning, and the staff's training to handle difficult resident behaviors. Avera Eureka Health Care Center was found in compliance. | F0000 | | |
| F0578<br>SS = E | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br><br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br><br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br><br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. | F0578 | For residents 5,6,7,8,12,22,31,39,40 and any other affected residents not listed on CMS-2567, paper consent forms for resuscitation status (Statement of Understanding: Resuscitation Status, Form 0066-53) have been completed for 100% of residents as of 6/30/26 by licensed nurses. In accordance with Avera policy 19158923 LTC Code Status/Resuscitation - System Standard Policy, the provider is responsible to document in the chart the rationale supporting the Resuscitation Status order as well as the risks, benefits and choices that were discussed with the resident (if competent) and with the family if resident is not conscious or competent. Provider documented rationale will be documented in 100% of resident charts by resident's primary providers by 7/13/26. Moving foward, all newly admitted residents (or<br><br>continued.... | 7/13/26 |

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 |
|---|---|---|
| Carmen Weber | Administrator | 7/9/2026 |

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| F0578 SS = E | Continued from page 1<br><br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br><br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.<br><br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review, interview, and policy review, the provider failed to ensure the code status (emergent treatment a person wishes to receive if their heart or breathing would stop) for ten of ten sampled residents (5, 6, 7, 8, 12, 22, 31, 39, 40, and 45) was documented in the residents' electronic medical records (EMR).<br><br>Findings include:<br><br>1. Review of resident 7's EMR revealed she admitted to the facility on 10/11/23. Her 4/24/26 Minimum Data Set (MDS) assessment indicated that she was rarely understood or able to understand others and was severely cognitively impaired. There was no documentation indicating that any advance directive (a document that expresses a person's health care wishes if they become unable to speak for themselves) paperwork was completed upon admission.<br><br>A copy of her Durable Power of Attorney (someone designated on a legal document to act on behalf of a resident) was scanned into the Meditech EMR, but it did not address her code status. A 5/18/26 physician's order indicated her code status was DNR/DNI. There was no physician documentation supporting that code status order or indicating that her wishes were discussed with the resident or the resident's representative.<br><br>2. Review of resident 8's EMR revealed she admitted to the facility on 3/17/26. Her 3/27/26 Brief | F0578 | designated representative) will be issued the Statement of Understanding: Resuscitation Status Form 0066-53 upon admission and this will be completed upon admission. The admitting provider will document the discussion held with resident/resident representative regarding resuscitation status per policy. Beginnning 7/13/26, Director of Nursing, Nurse Manager or other Registered Nurse designee will audit each new admission to ensure that resuscitation status requirements have been fully met including an active order in the electronic medical record, documentation on the the Statement of Understanding: Resuscitation Status form and appropriate documentation written by the resident's provider regarding resuscitation status including rationale, risks, benefits, and choices discussed with resident and/or family. This will be audited weekly for 8 weeks to ensure compliance with policy. After 8 weeks of weekly audits demonstrating compliance, monitoring will reduce to twice monthly for 3 months. Audit results will be reported quarterly to the Quality Assurance Performance Improvement committee by Director of Nursing for 6 months. | |

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| F0578 SS = E | Continued from page 2<br>Interview of Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. There was no documentation indicating that any advance directive paperwork was completed upon admission. A 5/18/26 physician's order indicated her code status was DNR/DNI. There was no physician documentation supporting that code status order or indicating that her wishes were discussed with the resident or her representative.<br><br>3. Review of resident 22's EMR revealed he admitted to the facility on 3/26/24. His 4/6/26 BIMS assessment score was 00, which indicated his cognition was severely impaired. A 5/18/26 physician's order indicated his code status was DNR/DNI. There was no completed code status form in his EMR to indicate his wishes if his heart or breathing stopped. There was no documentation in his EMR that his wishes were reviewed with him or his representative.<br><br>4. Review of resident 40's EMR revealed he admitted to the facility on 7/15/25. His 6/12/26 BIMS assessment score was 11, which indicated his cognition was moderately impaired. A 5/18/26 physician's order indicated his code status was DNR/DNI. There was no completed code status form in his EMR to indicate his wishes if his heart or breathing stopped. There was no documentation in his EMR that his wishes were reviewed with him or his representative.<br><br>5. Review of resident 12's EMR revealed he admitted to the facility on 9/24/25. His 6/12/26 BIMS assessment score was 00, which indicated his cognition was severely impaired. A 5/18/26 physician's order indicated his code status was DNR/DNI. There was no completed code status form in his EMR to indicate his wishes if his heart or breathing stopped. There was no documentation in his EMR that his wishes were reviewed with him or his representative.<br><br>6. Review of resident 39's EMR revealed he admitted to the facility on 3/10/26. His 6/12/26 BIMS score was 5, which indicated his cognition was severely impaired. A 5/18/26 physician's order indicated his code status was DNR/DNI. There was no completed code status form in his EMR to indicate his wishes if his heart or breathing stopped. There was no documentation in his EMR that his wishes were reviewed with him or his representative. | F0578 | | |

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| F0578 SS = E | Continued from page 3<br><br>7. Review of resident 6's EMR revealed he admitted to the facility on 10/27/22. His 3/10/26 BIMS assessment score was 00, which indicated his cognition was severely impaired. A 5/18/26 physician's order indicated his code status was DNR/DNI. Her EMR banner indicated her code status was DNR/DNI.<br><br>His 7/13/20 Durable Power of Attorney indicated, "I direct that life-prolonging treatment be withheld or withdrawn and that I be permitted to die naturally if two physician's certify that: (a) I am in a terminal condition that is an incurable or irreversible condition which, without the administration of life-prolonging treatment, will result in imminent death; (b) The application of life-prolonging treatment would serve only to artificially prolong the process of my dying; and It is my intention that this declaration be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and that they accept the consequences of that refusal, which is death." There was no documentation in resident 6's EMR to indicate that two physicians had certified his condition to be terminal or incurable.<br><br>8. Review of resident 5's EMR revealed he admitted to the facility on 7/1/25. His 5/12/26 BIMS assessment score was 14, which indicated his cognition was intact. A 5/18/26 physician's order indicated his code status was to be a full code (all resuscitation measures were to be implemented). His EMR banner indicated his code status was to be full code. There was no completed code status form in his EMR to indicate his wishes if his heart or breathing stopped. There was no documentation in his EMR that his wishes were reviewed with him or his representative.<br><br>9. Review of resident 31's EMR revealed she admitted to the facility on 8/6/25. Her 4/7/26 BIMS assessment score was 00, which indicated her cognition was severely impaired. A 5/18/26 physician's order indicated her code status was DNR/DNI. Her EMR banner indicated her code status was DNR/DNI. Her 2/10/18 Living Will indicated, "Provide life-sustaining treatment only if I have detectable brain activity, and there is a reasonable possibility of restoring to me the ability to thinks and act for myself. If my heart stops, provide restoration treatment until there is no hope of regaining a heartbeat." There was no documentation | F0578 | | |

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| F0578 SS = E | Continued from page 4<br>in her EMR that her wishes had changed since she signed her Living Will on 2/10/18.<br><br>10. Review of resident 45's EMR revealed she admitted to the facility on 9/22/25. Her 4/7/26 BIMS assessment score was 0, which indicated her cognition was severely impaired. A 5/18/26 physician's order indicated her code status was DNR/DNI. There was no completed code status form in her EMR to indicate her wishes if her heart or breathing stopped. There was no documentation in her EMR that her wishes were reviewed with her or her representative.<br><br>11. Interview on 6/11/26 with director of nursing (DON) B revealed there was no documentation in residents' 5, 6, 7, 8, 12, 22 31, 39, and 45 EMRs to support their code status that was indicated on their EMR banners were discussed with that resident or the resident's representative to be sure the resident's wishes would be followed if their heart or breathing stopped.<br><br>The provider did not have documentation that two physicians had certified that resident 6 had a terminal condition that was incurable or irreversible, as his Durable Power of Attorney indicated was his wish.<br><br>She acknowledged that the staff could not determine if resident 31 had brain activity, or if there was a reasonable possibility of restoring her to the ability to think or act by herself when her breathing or her heart stopped as her Living Will stated was her wish.<br><br>12. Review of the provider's October 2025 Code Status/Resuscitation policy revealed that when a resuscitation decision has been made, the physician was responsible for documenting in the chart the rationale supporting the physician's order for resuscitation status. The physician also must document the risks, benefits, and choices that were discussed with the resident and with the family. | F0578 | | |
| F0700 SS = E | Bedrails<br><br>CFR(s): 483.25(n)(1)-(4)<br><br>§483.25(n) Bed Rails.<br><br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure | F0700 | For residents 1,9,10,32,34,35,36,43,47 and any other affected residents not listed on CMS-2567, "T shaped poles used as assistive device will be removed by 7/26/26. By 7/26/26 residents who request an assistive device will have a completed risk/ safety assessment. If deemed<br><br>continued... | 7/26/26 |

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| F0700 SS = E | Continued from page 5<br>correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, record review, and policy review, the provider failed to ensure the manufacturer's instructions were followed for the installation of assistive devices ("T" Shaped poles attached to the residents' bed frames to be used for bed mobility) to the residents' beds, alternatives to the assistive devices were attempted before the assistive devices were installed, and the date of installation was documented for nine of nine sampled residents (1, 9, 10, 32, 34, 35, 36, 43, and 47), a physician's order was obtained before the installation of the assistive device for five of nine sampled residents (1, 9, 32, 34, and 47), a safety assessment was completed for four of nine sampled residents (1, 9, 34, and 35), and informed consent was obtained for the use of the assistive device for two of nine sampled residents (9 and 34) who had assistive devices on their beds.<br><br>Findings include:<br><br>1. Observation and interview on 6/9/26 at 10:03 a.m. with resident 9 in her room revealed that she had an assistive device attached to the right side of her bed, which she used to reposition herself in bed. She was unsure whether she was educated about the risks and benefits of the assistive device.<br><br>Review of resident 9's electronic medical record (EMR) revealed she admitted to the facility on 2/12/25. There was no documentation of prior interventions attempted before her assistive device | F0700 | appropriate, a physician's order will be obtained and placed in electronic medical record, informed consent will be obtained and a date of installation will be documented. If assist rail is applied to bed frame, it will be a compatible product per manufacturer guidelines and will meet criteria per Avera policy. Facility will ensure that assistive device meets measurement criteria for safety per regulation. Beginning on 7/26/26, Director of Nursing, Nurse Manager or other Registered Nurse designee will audit the chart of any resident using an assistive mobility device for physician's order, completed saftey assessment, informed consent and date of installation weekly for 8 weeks to ensure compliance. After 8 weeks of weekly audits demonstrating compliance, monitoring will reduce to twice monthly for 3 months. Audit results will be reported to the Quality Assurance Performance Improvement Committee by Director of Nursing for 6 months.<br><br>Addendum: Risk/safety assessment will be completed by Director of Nursing, Nurse Manager or other designated nurse before placement of a device to determine if a less restrictive alternative can be trialed such as physical therapy evaluation/treatment, occupational therapy evaluation/treatmen and/or restorative therapy program. A risk/ safety assessment will also be completed quarterly and with any change in condition by Director of Nursing, Nurse Manager or other designated nurse. Informed consent will be obtained, risk/safety assessment will be completed with resident and/or other representative, education will be<br><br>continued... | 7/9/26 |

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| F0700 SS = E | Continued from page 6<br>was installed, a signed consent, a physician's order for the use of the assistive device, or a quarterly assessment completed to assess her safe use of the assistive device. There was no documentation of the date the assistive device was applied to her bed.<br><br>2. Observation on 6/9/26 at 10:04 a.m. in resident 34's room revealed she had an assistive device attached to the left side of her bed.<br><br>Review of resident 34's EMR revealed she admitted to the facility on 2/1/23. There was no documentation of prior interventions attempted before her assistive device was installed, a signed consent, a physician's order for the use of the assistive device, or a safety assessment completed to assess her safe use of the assistive device. There was no documentation of the date the assistive device was applied to her bed.<br><br>3. Observation on 6/9/26 at 10:24 a.m. in resident 35's room revealed there was an assistive device attached to the left side of his bed.<br><br>Review of resident 35's EMR revealed that he admitted to the facility on 6/21/21. There was no documentation of prior interventions attempted before his assistive device was installed, nor of a safety assessment completed to evaluate his safe use of the device. There was no documentation of the date the assistive device was applied to his bed.<br><br>4. Observation on 6/9/26 at 10:38 a.m. in resident 43's room revealed that she had mobility bars on the left and the right side of her bed. The bed rail was attached to the bottom of the bed frame with a pole coming up vertically from that bed frame. The vertical pole had a horizontal pole on it to make a "T" shape. The right vertical bar had a gap of 30 inches from the head of her bed to that vertical pole, while the left vertical bar had a gap of 23.5 inches from the head of her bed to that vertical pole. The right horizontal bar had a gap of 6 inches from the top of the mattress to the bar while the left horizontal bar's gap was 7 inches.<br><br>Review of resident 43's electronic medical record (EMR) revealed that she was admitted on 10/9/20. She had a 7/22/22 physician's order for the bed rail. She had signed consent for placement of the bar on 11/22/22 and that consent listed risks and benefits of bed rail use. The provider could not provide documentation that alternatives were tried before use of the bed rail, an entrapment risk assessment was completed, or the date that the bed rail was applied. | F0700 | provided and discuss any risks/benefits and a date of installation will be documented. | |

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| F0700 SS = E | Continued from page 7<br><br>5. Observation on 6/9/26 at 10:38 a.m. in resident 10's room revealed that she had mobility bars on both sides of her bed. The gap from the head of the bed to the vertical bar on the right side of her bed was 29 inches. That bed rail had a gap of 9 inches from the top of her mattress to the vertical rail. The bed rail was able to move 3 inches when it was shaken from the direction of the top of the bed to the foot of the bed. From side to side, that rail was able to move 1.5 inches.<br><br>Review of resident 10's EMR revealed that she was admitted on 8/4/20. She had a 7/29/22 physician's order for the bed rail. She had signed a consent for the placement of the bar on 11/22/22. That consent listed risks and benefits. The provider could not provide documentation that alternatives were tried before use of the bed rail, an entrapment risk assessment was completed, or the date that the bed rail was applied.<br><br>6. Observation and interview on 6/9/26 at 3:11 p.m. with resident 1 in his room revealed he had assistive devices attached on both sides of his bed, which he used "to get in and out of bed."<br><br>Review of resident 1's EMR revealed that he admitted to the facility on 12/6/23. There was no documentation of prior interventions attempted before the assistive devices were installed, no physician's order for the use of the assistive devices, and no safety assessment was completed to evaluate his safe use of the device. There was no documentation of the date the assistive devices were applied to his bed.<br><br>7. Observation and interview on 6/9/26 at 4:01 p.m. in resident 36's room revealed that she had a bed rail on the right side of her bed that she used to get her from a seated to a standing position. She could not recall if she had been assessed or educated on the use of those bed rails.<br><br>Review of resident 36's EMR revealed that she was admitted on 11/20/20. She had a Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated that her cognition was intact. She had a 2/7/23 provider's order for the use of a mobility device, with the comment "assist pole to the right side of bed to assist with bed mobility." The provider could not provide documentation that alternatives were tried before use of the assistive device, or the date that the assistive device was applied. | F0700 | | |

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| F0700 SS = E | Continued from page 8<br>8. Review of resident 47's EMR revealed that she was admitted on 10/1/25. She had a 10/2/25 nursing note that indicated that she had requested a nurse apply an assistive device for help with mobility in bed. The note indicated that a consent was signed for a left bed assistive device. The provider could not provide documentation that alternatives were tried before the assistive device was installed, a physician's order for use of an assistive device, or the date that the assistive device was installed on her bed.<br><br>9. Review of resident 32's EMR revealed that he was admitted on 8/15/23. He had a signed consent for the use of a left assistive device on 9/8/23 that listed the risks and benefits of having an assistive device attached to the bed. The provider could not provide documentation that alternatives were tried before use of the assistive device, a signed physician's order for the device, or the date that the device was installed on his bed.<br><br>10. Interview on 6/11/26 at 10:46 a.m. with licensed practical nurse (LPN) E regarding resident assistive devices revealed that the nursing staff was responsible for obtaining the resident's consent, going over risks and benefits, assessing the safety risk, documenting alternatives, and obtaining a physician's order prior to a resident getting an assistive device installed on their bed. She was aware that some of the assistive devices were able to move and that they were not supposed to move. If they moved, nursing was expected to put in a work order for the maintenance staff to assess the assistive device. She was also aware that some of the residents' assistive devices were able to be lifted off the bed mount. She could not recall if staff received any education regarding the new assistive devices because they were purchased and applied several years ago.<br><br>11. Interview on 6/11/26 at 2:50 p.m. with facilities coordinator I revealed that he would get the approval from director of nursing (DON) B before applying an assistive device to a resident's bed. He did not like the mount that came with that assistive device to mount it to the resident's bed securely, so he made his own mount bracket to apply the bar to the resident's bed.<br><br>The nursing staff performed the safety assessments. He was aware that the assistive devices were able to be moved in different positions depending on the resident's physical needs. He was not aware that some of the assistive devices were able to be lifted completely off the mount that kept them attached to | F0700 | | |

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|---|---|---|---|
| | 435078 | A. BUILDING<br>B. WING | 06/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **Avera Eureka Health Care Center** | **202 J AVENUE POST OFFICE BOX 40, EUREKA, South Dakota, 57437** |

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| F0700<br>SS = E | Continued from page 9<br>the resident's bed.<br><br>12. Interview on 6/11/26 at 4:21 p.m. with DON B revealed that she was not aware that the current assistive devices were not compatible with the resident's current bed frames per the manufacturer's manual. She agreed this could cause a risk for entrapment. She agreed that there was no documentation that alternatives were attempted before applying the bed rails for any of the current residents with those bed rails. She could not provide documentation of the date that the bedrails were applied to the beds for residents 1, 9, 10, 32, 34, 35, 36, 43, and 47.<br><br>13. Review of the provider's April 2026 Physical Restrain/Bed Mobility Device policy revealed that gaps or widths between handles on devices must be less than 4 ¾ inches. When considering if a resident was appropriate for use of a bed rail, "the least restrictive method will be tried first and the results documented." The policy also stated that "bed mobility devices will not be offered as part of routine care" and "family or surrogates of [the] resident may not request [a] bed mobility device." A physician's order must be obtained for the use of the bed mobility device, and that device must be in the care plan, reviewed quarterly by the interdisciplinary team, and documented on the usage every shift.<br><br>14. Review of the 2012 Invacare CS Series Beds User Manual stated to "only use Invacare rails....and other accessories with Invacare bed products" and that the "use of non-Invacare bed accessories may result in injury or death." In the "bedrail entrapment risk notification" section of the user manual, a bullet point read, "Invacare homecare beds are specifically designed and manufactured for use in conjunction with Invacare accessories, including bed rails." The end of this section in the user manual noted that "use of other manufacturer's products in conjunction with an Invacare homecare bed may significantly increase the risk of entrapment; as such Invacare does not recommend their use."<br><br>15. Review of the ER100 Bedside Balance Assist Rail installation instructions revealed that "incorrect installation or incorrect use of ER100 can result in serious injury or death." | F0700 | | |
| 0812<br>S = D | Food Procurement,Store/Prepare/Serve-Sanitary<br><br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements. | F0812 | | |

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| F0812 SS = D | Continued from page 10<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and policy review, the provider failed to ensure one of one walk-in refrigerators were free from rust on the metal wire storage shelf that had flaked off and landed on the uncovered raw vegetables that were stored on that metal wire shelf.<br><br>Findings include:<br><br>1. Observation on 6/9/26 at 9:53 a.m. in the kitchen walk-in refrigerator revealed four metal wire shelves. The metal shelves had started to rust, and some rust flakes were on the floor. The bottom metal wire shelf had several cardboard boxes of raw vegetables including a box of onions with rust flakes.<br><br>2. Interview with food service manager J on 6/10/26 at 1:56 p.m. revealed he was aware of the rust on the metal wire shelves in the walk-in refrigerator. He stated that the rust can "flake" off those metal wire shelves and potentially land on uncovered raw foods such as vegetables. If the rust were to land on a vegetable like a broccoli stalk, then he would not be able to clean off the rust flakes, and they could potentially end up in the residents' meals.<br><br>3. Review of the provider's September 2025 | F0812 | A new set of Polypropylene shelves were ordered for the walk-in refrigerator on 6/29/26 from US foods. Confirmation of the order was received from US Foods stating the shelves were ordered but will not be delivered until 8/11/26. Until the new shelves are received, the current four metal wire shelves will be removed from the walk-in refrigerator and a different set of rust free wire shelves will be put into the walk-in refrigerator. The new set of Polypropylene shelves will be installed as soon as they are received. The Dietary manager will report to the Quality Assurance Performance Improvement committee at the next quarterly meeting that the four metal shelves were removed from the walk-in refrigerator and will be replaced with the new set of Polypropylene shelves as soon as they are received. | 7/26/26 |

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| F0812 SS = D | Continued from page 11 Standard Food Storage Guidelines revealed that food storage areas should be clean to prevent contamination and illness to the residents. | F0812 | | |

South Dakota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10618 | A. BUILDING: _____ B. WING _____ | 06/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AVERA EUREKA HEALTH CARE CENTER | 202 J AVENUE EUREKA, SD 57437 |

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| S 000 | Compliance/Noncompliance Statement<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/9/26 through 6/11/26. Avera Eureka Health Care Center was found not in compliance with the following requirement: S206. | S 000 | | |
| S 206 | 44:73:04:05 Personnel Training<br><br>The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects:<br>(1) Fire prevention and response;<br>(2) Emergency procedures and preparedness;<br>(3) Infection control and prevention;<br>(4) Accident prevention and safety procedures;<br>(5) Proper use of restraints;<br>(6) Resident rights;<br>(7) Confidentiality of resident information;<br>(8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms;<br>(9) Care of residents with unique needs;<br>(10) Dining assistance, nutritional risks, and hydration needs of residents;<br>(11) Abuse and neglect; and<br>(12) Advanced directives.<br><br>Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section.<br><br>The facility shall provide additional personnel education based on the facility's identified needs. | S 206 | CNA F's assigned required annual training was completed on 6/10/26. Other employees of the facility will have their assigned required annual training completed by 7/26/26. Administrator will audit education completion reports quarterly for one year to ensure all current and new staff have required annual education training or new hire education done timely. Administrator will report results of the audits to the Quality Assurance Performance Improvement Committee quarterly for one year.<br><br>The lesson Avera 1431 Reporting of Communicable Diseases was assigned to Employee F,K,L,M and all non-clinical staff and Certified nurses assistants to be completed by 7/25/26. This lesson was already assigned and completed by all RN's and LPN's in the facility. The lesson Riskonnect for mandatory reporting of incidents was assigned to all staff on 5/4/26 and will be completed by 7/25/26. Administrator will do weekly audits of the education completion reports for the next 4 weeks to make sure the lessons are completed by all staff. Administrator will report the findings of the audit to the Quality Assurance Performance Improvment committee quarterly for the next 2 meetings.<br><br>continued... | 7/26/26 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Carmen Weber | Administrator | 7/10/26

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10618 | A. BUILDING: _____ B. WING _____ | 06/11/2026 |

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| S 206 | Continued From page 1<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on employee record review, interview, and policy review, the provider failed to ensure two of three employees reviewed (F and M) completed the required annual training.<br><br>Findings include:<br><br>1. Review of certified nursing assistant (CNA) F's employee record revealed she was hired on 3/26/24. She did not complete the required annual training regarding the topics of fire prevention and response, emergency preparedness and procedures, infection prevention and control, accident prevention and safety procedures, proper use of restraints, resident rights, confidentiality of resident information, mandatory reporting of incidents and diseases, care of residents with unique needs, dining assistance nutritional risks and hydration, abuse and neglect, and advanced directives.<br><br>2. Review of activity assistant M's employee record revealed she was hired on 6/13/23. She did not complete the required annual training regarding the topic of mandatory reporting of incidents and diseases.<br><br>3. Interview on 6/10/26 at 4:30 p.m. with administrator A revealed CNA F did not complete any of the required annual training. Administrator A contacted CNA F on 6/10/26 and advised her to complete it.<br><br>4. Review of a 6/11/26 email from talent development coordinator D to administrator A regarding activity assistant M's annual training revealed talent development coordinator D | S 206 | Administrator will work with Avera Education to ensure lessons for mandatory reporting of incidents and communicable diseases are added to the list of required education and are assigned to all staff when newly hired or as part of their annual mandatory education.<br><br>Addendum: Avera Education, Quality and Data Integration Senior Services officer of Avera Health, Employee Health and Infection Prevention will be meeting to review mandatory education and ensure Mandatory Incident Reporting/ Communicable Diseases training is included in our list of required education by 7/26/26. | 7/26/26 |

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| | 10618 | A. BUILDING: _____ B. WING _____ | 06/11/2026 |

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| S 206 | Continued From page 2<br>indicated that the non-nursing staff only needed regulatory compliance education to meet the requirements for the mandatory reporting of incidents and diseases.<br><br>5. Interview and review of the provider's 2026 Regulatory Compliance Education on 6/11/26 at 3:24 p.m. with administrator A revealed the annual employee training was assigned to each employee by the corporate office. The employees and their department managers were responsible for ensuring the required training was completed. Some of the required training was within a grouped heading such as "annual education" or "regulatory compliance" and the managers could not see what was under each of the grouped educations to ensure the required education was completed, only that the assigned training was completed.<br><br>The Regulatory Compliance Education learning objectives indicated, "Employee Illness, Injuries and Return to Work" was the objective that administrator A was told by talent development coordinator D satisfied the mandatory reporting of incidents and diseases education.<br>The education within that objective was, "If you are experiencing any of the following symptoms DO NOT report to work and Contact Employee Health at [redacted telephone number] for evaluation (after hours leave a message for a return call): Fever or chills, Cough or congestion, Shortness of breath or difficulty breathing, Muscle or body aches, New loss of taste or smell, Sore throat, Vomiting or Diarrhea."<br><br>6. Review of the provider's 7/2/24 Education-Development policy revealed, "Mandatory Education Requirements (Joint Commission, OSHA [Occupational Safety and | S 206 | | |

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| | 10618 | A. BUILDING: _____ B. WING _____ | 06/11/2026 |

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| S 206 | Continued From page 3<br>Health Administration], State, DOT [Department of Transportation]) are required for all employees. It is expected that all employees complete [the] new hire education, annual mandatory education, and ongoing designated mandatory education as a mechanism to ensure competency. This expectation includes PRN [as needed] employees." | S 206 | | |

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| E0000 | Initial Comments<br><br>A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 6/9/26. Avera Eureka Health Care Center was found in compliance. | E0000 | | |

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other afeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 0 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 4 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 ·ogram participation.

| ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Carmen Weber | Administrator | 07/06/2026 |

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| | 435078 | A. BUILDING **01 - MAIN BUILD...** B. WING | **06/09/2026** |

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| K0000 Bldg. 01 | INITIAL COMMENTS<br><br>A recertification survey was conducted on 6/9/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avera Eureka Health Care Center was found in compliance. | K0000 | | |

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other afeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable ) 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 4 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 ·ogram participation.

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| Carmen Weber | Administrator | 07/06/2026 |