DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. BUILDING B. WING	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 E 8TH ST , WINNER, South Dakota, 57580

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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 7/21/26 through 7/23/26. The area surveyed was related to the report of resident abuse by a staff member. Winner Regional Healthcare Center was found not in compliance with the following requirement: F610.	F0000		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to ensure a thorough investigation was completed regarding an allegation of resident abuse for one of one resident (1) by one of one former contracted travel certified nursing assistant (CNA) (G) who bruised resident 1's upper right arm while providing her personal care.	F0610	Because the facility had already completed its investigation of the abuse and neglect allegation and had taken corrective action regarding the contract employee, we are unable to reinvestigate that specific matter.	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	10-Aug-26

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F0610 SS = D	Continued from page 1 Findings include: 1. Review of the provider's 6/20/26 FRI revealed on 6/20/26 at approximately 3:30 p.m. resident 1 told CNA E that she had right arm pain. While CNA E was providing personal care for resident 1, CNA E saw bruising on resident 1's right upper arm. CNA E asked resident 1 what the bruises were from and resident 1 told her that the CNA from the night before had hurt her arm when the CNA changed resident 1's incontinence (involuntary urine or bowel leakage) brief. The CNA had grabbed resident 1's arm and told resident 1 to turn onto her side while lying in bed. Resident 1 told the CNA that she could not turn onto her side because she had a stroke (blood flow to a part of the brain is blocked or a blood vessel in the brain bursts) and she could not use her right arm. The CNA repeatedly requested resident 1 to turn onto her side. The CNA became upset and stated, "Yes, well everyone here has had a stroke", grabbed resident 1's arm, and "flung it over." CNA E told contracted travel registered nurse (RN) D about the bruising on resident 1's right upper arm and the allegation of abuse. On 6/20/26 at approximately 3:30 p.m. contracted travel RN D called director of nursing (DON) B to notify her of the new bruises on resident 1's right upper arm and her allegation of abuse. When DON B spoke with resident 1 she recalled the incident as she had told CNA E. Resident 1 stated she did not know the CNA's name from the night before but was able to describe her. The CNA was determined by DON B to be former contracted travel CNA G. 2. Review of resident 1's electronic medical record (EMR) revealed she admitted to the facility on 3/4/26. Her 6/30/26 Brief Interview for Mental Status (BIMS) assessment score was 11, which indicated her cognition was moderately impaired. Her diagnoses included cerebral infarction (a stroke), and hemiplegia and hemiparesis (weakness and paralysis of one side of the body) following a cerebral infarction affecting the dominant right side. A 6/20/26 progress note, written by contracted travel RN D stated, "Writer was called to resident's room this afternoon at 1540 [3:40 p.m.] to assess some bruises on resident's right upper bicep. Writer notes several nickel-size bruises to this area. Resident also stated this area 'hurts.' [Title] Skin [was] intact, no open areas. When writer asked [the] resident what happened to cause these bruises,	F0610	The DON and Administrator reviewed the Abuse and Investigation Policy and removed the Investigation form from the policy and revised the investigation form as a standalone form for all state reportable incidents to support thorough investigations by the responsible administrative staff member. Members of IDT were educated by the LTC administrator concerning the new form for more effective and thorough investigations and timeliness of the investigations and reports to the state. In addition, IDT members were retrained on the following policies; Abuse, Neglect, Exploitation, and Misappropriation Prevention Policy; and the Abuse and Incident Investigation Policy. Once a state reportable investigation has occurred the IDT will review the investigation form in IDT which will include, the findings of the investigation, and timeliness of the reporting of the investigation, and completeness of the investigation. The investigation form is to be signed by the DON and LTC Administrator after IDT has reviewed the form. The findings of IDT concerning investigations will be presented to the QAPI committee on a quarterly basis by the LTC Administrator or designee for a period of 12 months for review and recommendations. All RN's and LPN's received education from the DON concerning the new investigation form and the Abuse and Incident Investigation Policy.	08/09/2026

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F0610 SS = D	Continued from page 2 resident stated [state], 'That girl changing me last night told me to move my (right) arm to the left and turn on my side. I told her I couldn't move that arm.' Resident went on to stated, 'She asked me again, and I told her again that I couldn't move my (right) arm. So she grabbed my (right) arm and flung it over so she could turn me.'" The first documented full body skin assessment was completed on 6/22/26, two days after resident 1's allegation of abuse. That skin assessment revealed she had bruises on both of her outer arms, in different stages of healing. Her 7/21/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated she was dependent on the staff to turn and reposition her in bed.ee 3. Review of the provider's 6/20/26 investigationee regarding resident 1's bruises and allegation of abuse revealed DON B interviewed resident 1 about the abuse allegation. DON B then asked residents 2 and 3, "Have you been having any problems with any of the CNAs?" Resident 3 stated she did not have any problems with any of the CNAs. Resident 2 stated there was one CNA that worked the night shift that was "pretty rough." No other resident interviews were completed to determine if other residents had received rough care or had allegations of abuse. DON B interviewed CNA E and contracted travel RN D about what resident 1 had reported to them, and the bruises. DON B did not interview former contracted travel CNA G about the allegation. DON B did not interview the nurse who worked on 6/19/26, when the incident was reported to have happened. She did not interview contracted travel CNA F, who was training contracted travel CNA G on 6/19/26. 4. Interview on 7/21/26 at 12:45 p.m. with DON B revealed she had interviewed the residents on the 200 hallway whose cognition was "good enough" to answer if they had trouble with any CNAs. She did not interview any residents down the 300 hallway because former contracted travel CNA G was not scheduled to work in that hallway. Former contracted travel CNA G could not be interviewed because DON B did not have her contact information. 5. Review of the BIMS assessment scores for the residents on the 200 hallway revealed there were five residents (2, 3, 4, 5, and 6) whose BIMS assessment	F0610	Before IDT education on the new WRH LTC investigation form, the Administrator received a grievance from a resident's significant other. Although the grievance did not include allegations of abuse, neglect, or a state reportable, the Administrator used the form to evaluate its efficiency, thoroughness, and accuracy. Following that review, the IDT was educated on the form and provided an example of its proper use.	

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F0610 SS = D	Continued from page 3 scores indicated they were cognitively intact. 6. Phone interview on 7/21/26 at 1:00 p.m. with CNA E revealed she assisted resident 1 to get up and dressed for lunch on 6/20/26. Resident 1 had told her that her right arm hurt when CNA E was helping her, but resident 1 had a history of arthritis pain. Resident 1 then told her that the night CNA had thrown her arm against the wall. After lunch CNA E, assisted resident 1 to change her shirt and resident 1 told her that the night CAN had told resident 1 to move her arm. Resident 1 told former contracted travel CNA G that she could not move her arm because she had a stroke. Former contracted travel CNA G told resident 1 she could move her arm and that all the residents at that facility had strokes. Resident 1 stated that former contracted travel CNA G repeated herself several times and then threw resident 1's right arm against the wall. While changing resident 1's shirt CNA Esaw bruising on resident 1's right upper arm. There was one larger bruise with smaller bruises surrounding the larger bruise. CNA E notified contracted travel RN D of resident 1's allegations of abuse and the bruises on her right upper arm. Contracted travel RN D came into resident 1's room, talked with resident 1 and looked at the bruises. Contracted travel RN D then called DON B. DON B came to the facility shortly after contracted travel RN D called her and started interviewing resident 1, contracted travel RN D, and CNAE. 7. Phone interview on 7/21/26 at 3:30 p.m. with contracted travel RN D revealed she was notified by CNA E that resident 1 stated former contracted travel CNA G told resident 1 several times to roll herself over. Resident 1 told former contracted travel CNA G that she could not roll over because she had a stroke and could not use her right arm. Former contracted travel CNA G had thrown resident 1's arm over to change resident 1's incontinence brief, which resulted in bruises on resident 1's right upper arm. Contracted travel RN D had went into resident 1's room after CNA E informed her of resident 1's bruises. Resident 1 told her about former contracted travel CNA G throwing her ann. While resident 1 was describing the incident to contracted travel RN D, resident 1 was holding her right upper arm with her left hand. Resident 1 stated that she had pain in her	F0610		

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F0610 SS = D	Continued from page 4 right upper arm. Contracted travel RN D looked at the skin on resident 1's upper right arm and saw three bruises. Contracted travel RN D called DON B to notify her of the bruises and abuse allegation, DON B came to the facility and started an investigation. 8. Interview on 7/21/26 at 4:20 p.m. with resident 1 in her room revealed that on the night of 6/19/26, former contracted travel CNA G came into resident 1's room to change resident 1's incontinence brief. Resident 1 attempted to assist former contracted travel CNA G with turning onto her side by using her left arm and the side rail (bar/bars attached to the bed). Former contracted travel CNA G kept telling resident 1 to roll onto her side. Resident 1 told former contracted travel CNA G multiple times that she was unable to roll onto her side because she had a stroke and could not use her right arm. Former contracted travel CNA G "slammed" resident 1's right arm against the wall and it bruised her right upper arm. Resident 1 stated that former contracted travel CNA G kept "slamming" her around that night. She said former contracted travel CNA G "slammed me this way" and pointed to her left, and then she "slammed me this way" and pointed to her right. Resident 1 told former contracted travel CNA G that she was hurting her, but former contracted travel CNA G did not stop. Resident 1 stated she told another staff member what had happened the next morning 6/20/26. That morning her arm hurt. 9. Interview on 7/22/26 at 8:00 a.m. with administrator A revealed the nurse who worked the night shift on 6/19/26 was no longer employed by the provider and could not be interviewed. 10. Phone interview on 7/22/26 at 9:00 a.m. with contracted travel CNA F revealed she was training former contracted travel CNA G the night of 6/19/26. She did not know about the incident with resident 1 until the next day, when it was passed on during the nursing shift report. She did not have any concerns with former contracted travel CNA G's interactions with the residents. On 6/19/26 former contracted travel CNA G had refused to provide cares or answer resident 1's call light because she stated resident 1 was mean to her. Then when contracted travel CNA F came out of another resident's room, former contracted travel CNA G told her she had gone into resident 1's room and changed her	F0610		

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F0610 SS = D	Continued from page 5 incontinence brief. Contracted travel CNA F stated resident 1 was able to tell the staff when she had pain or if they were being rough during cares. Contracted travel CNA F stated that she had trained former contracted travel CNA G on both the 200 and 300 hallways. The CNAs on the night shift provided care to the residents on both hallways every night because the 200 and 300 hallways have residents that require the assistance of two staff members. 11. Interview on 7/23/26 at 11:10 a.m. with DON B revealed she had interviewed contracted travel RN D, CNA E, and resident 1 related to the 6/20/26 allegation of abuse. She acknowledged she did not interview other staff members who may have been involved or had information about the incident. She acknowledged that she did not interview other residents to determine if other residents may have been potentially abused by a staff member. She acknowledged that resident 1's first full body skin assessment was completed on 6/22/26. 12. Review of the provider's 6/15/26 Abuse, Neglect, Exploitation, and Misappropriation Prevention policy revealed, "The Administrator, Director of Nursing or designee shall: Initiate an Investigation immediately or within Federal Regulations, Interview involved individuals, Review medical records, Interview staff, Preserve documentation."	F0610		