

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/31/2026
NAME OF PROVIDER OR SUPPLIER AVANTARA NORTON			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE , SIOUX FALLS, South Dakota, 57105	
(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 recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/24/26 through 3/26/26 and from 3/30/26 through 3/31/26. Avantara Norton was found not in compliance with the following requirements: F550, F561, F578, F641, F655, F684, F688, F689, F697, F760, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/24/26 through 3/26/26 and from 3/30/26 through 3/31/26. Areas surveyed included resident rights and family members' access to a resident, quality of care and treatment provided by the staff related to a resident's bathing, following the resident's care planned interventions, the prevention of pressure ulcers, resident safety related to a resident who fell, and following physician orders. Other areas surveyed included allegations that a dietary staff member was potentially unqualified, the facility's response to residents and family members' concerns, an allegation of potential verbal and physical abuse to a resident by a staff member, allegations of potential resident neglect related to long call light wait times and a resident who was left unsupervised without having received care for an extended period, and an allegation that the provider was using expired resident care items. Avantara Norton was found not in compliance with the following requirements: F550, F561, F600, F684, F686, F688, and F689, and to have past noncompliance at F740. The current census was 102.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the	F0550	1. Residents #16, #74 were assessed on and their hygiene needs were addressed, including cleaning of face, hands, and changing soiled clothing on 04/30/2026. Resident #3 has discharged. Resident #16, #74 care plans were reviewed and updated to reflect ADL, hygiene, and privacy needs on 04/30/26.	05/08/2026

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 Ashley Nickel	TITLE Administrator	(X6) DATE 05/04/2026
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F0550 SS = D	<p>Continued from page 1 facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights.</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, record review, interview, and policy review, the provider failed to protect the residents' right to dignity and privacy for two of two observed sampled residents (16 and 74) with soiled clothing and unclean hands and faces, and one of one observed sampled resident (3) not provided privacy while receiving personal care in his shared room by two of two observed certified nursing assistants (CNA) (N and Q).</p> <p>Findings include:</p>	F0550	<p>2. All residents are at risk for deficient practice. A daily observation of residents across all shifts related to hygiene, cleanliness, and privacy practices during care will be completed by management staff. Any identified issues were corrected immediately.</p> <p>3. Root cause Analysis: The facility system failed due to all staff related to lack of education, monitoring and accountability for dignity practices related to cleaning of resident's faces, hands, and changing soiled clothing and use of privacy curtains during cares. New system implemented for resident room rounding by management 5 times a week to ensure privacy during cares. The Administrator or designee will educate all staff on dignity, hygiene, and privacy practices, including use of privacy curtains, no later than 05/08/2026. Those not in attendance at education sessions will be educated prior to their next shift worked.</p> <p>4. Administrator/designee will audit across all shifts, 5 total residents weekly for dignity, hygiene and privacy through observation x 6 weeks, then monthly x 2 months. Administrator or Designee will present audit findings monthly in QAPI meeting for progress review and recommendations.</p>	

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F0550 SS = D	<p>Continued from page 2</p> <p>1. Review of the provider's 3/17/26 SD DOH FRI regarding resident 16 revealed resident 16's family member reported concerns related to the quality of care being provided for resident 16.</p> <p>Resident 16's family member reported that she did not feel resident 16 was being changed regularly or was assisted out of her bed and taken to the dining room for meals.</p> <p>2. Observation on 3/24/26 at 2:23 p.m. of resident 16 in her room revealed she was sitting in her wheelchair with a dried green substance on her nose and, had a urinary catheter (flexible tubing placed in the bladder to drain urine).</p> <p>3. Observation on 3/24/26 at 3:47 p.m. of resident 16 in her room revealed she was lying in her bed and the dried green substance remained on her nose.</p> <p>4. Review of resident 16's electronic medical record (EMR) revealed she admitted to the facility on 3/2/26.</p> <p>Her 3/6/26 Brief Interview of Mental Status (BIMS) assessment score was 4, which indicated her cognition was severely impaired.</p> <p>Her diagnoses included depression and senile degeneration of the brain (a progressive age-related cognitive decline caused by brain cell death).</p> <p>Her 3/25/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated she had difficulty with communication and was to be asked yes or no questions. The staff were to provide resident 16 with clear, careful explanations to facilitate her understanding.</p> <p>Resident 16 required the assistance of one staff member with getting dressed, was dependent upon the staff for her personal hygiene needs, and was to be transferred between surfaces with the assistance of two staff members with the use of a full body lift (a mechanical lift and sling used to lift a person's full body).</p> <p>5. Interview on 3/25/26 at 2:50 p.m. with CNA/CMA R revealed director of nursing (DON) B and administrator A spoke with her about resident 16's family member's concern about resident 16 being left in her bed with</p>	F0550		

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F0550 SS = D	<p>Continued from page 3 her nightgown on until 2:30 p.m.</p> <p>CNA/CMA R stated she was not assigned to assist resident 16 with her cares prior to 3/17/26 when resident 16's family member expressed her concerns related to the care her mother had received by the staff.</p> <p>CNA/CMA R stated she had checked on resident 16 on 3/16/26 and asked her if she needed anything but resident 16 did not answer her so CNA/CMA R left her in her bed with her night gown on.</p> <p>6. Interview on 3/30/26 at 2:08 p.m. with resident 16's family member on the phone revealed she had spoken with administrator A about her concerns related to the quality-of-care resident 16 received from the staff.</p> <p>Resident 16's family member stated that the resident was unable to use her call light to ask for assistance by the staff and was dependent on the staff for assistance with all of her personal care needs.</p> <p>About one week after resident 16 admitted to the facility, resident 16 was lying in her bed and spilled her juice on her stomach and her bed sheets. Resident 16's family member visited later that day and saw she had spilled juice on herself. The next day resident 16's family member arrived at the facility to visit the resident and noticed the resident's bed sheets were not changed because the dried juice stain was still on them.</p> <p>She came to visit resident 16 one day around 2:30 p.m. and found her lying in her bed, in her pajamas with food on her face and clothing. She was unable to remember the date of that observation but stated it was close to the day that she expressed her concerns to the administrator (3/17/26).</p> <p>On 3/17/26 resident 16's family member told administrator A that she wanted the resident to be out of bed to eat lunch and supper in the dining room and not be left uncared for in her room.</p> <p>7. Interview on 3/31/26 at 1:41 p.m. with administrator A revealed she had completed the 3/17/26 DOH FRI. Resident 16's family member expressed her concerns about the quality-of-care resident 16 received from the staff to administrator A.</p> <p>Resident 16 refused some cares the staff offered her</p>	F0550		

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F0550 SS = D	<p>Continued from page 4 and at times refused to get out of bed for meals. Administrator A reviewed resident 16's EMR during her investigation of resident 16's family member's concerns and determined that the CNAs documented resident 16's clothing and incontinence (involuntary urine or bowel leakage) products were changed.</p> <p>8. Observation on 3/24/26 at 9:06 a.m. of resident 74 revealed he was lying in his bed. He had a white shirt on that had multiple brown discolorations on the chest and arms of that shirt.</p> <p>9. Observation and interview on 3/24/26 at 11:33 a.m. with resident 74 in the dining room revealed he was wearing a white shirt with the brown discolorations on the chest and sleeves. He was drinking out of a handled mug. When he brought the mug towards his mouth, the brown liquid from the mug spilled out onto his clothing protector and shirt before he could bring the mug to his mouth. Resident 74 stated he was drinking coffee.</p> <p>During the lunch dining observation resident 74 continued to spill the coffee onto his clothing protector and shirt as he attempted to drink. The staff in the dining room did not offer assistance or interventions to avoid resident 74's drink spilling onto his clothing protector and shirt.</p> <p>10. Observation and interview on 3/24/26 at 2:44 p.m. with resident 74 in his room revealed he was lying in his bed, wearing the same white shirt with the brown discolorations on the chest and arms, and pieces of food were in his beard around his mouth.</p> <p>He stated he would have liked the staff to change his shirt because it was dirty, he had trouble with spilling food and drinks on his shirt at times and would like more assistance with eating and drinking.</p> <p>11. Observation on 3/30/26 at 1:03 p.m. of resident 74 sitting in his wheelchair in the hallway beside the nurses' stations revealed he had food in his beard and a thick orange substance on his fingers surrounding his fingernails.</p> <p>12. Observation on 3/30/26 at 3:27 p.m. of resident 74 sitting in his wheelchair in the hallway beside the nurses' station revealed he had thick orange substance on his fingers surrounding his fingernails, orange and</p>	F0550		

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F0550 SS = D	<p>Continued from page 5 white substances in his beard, and red and orange pieces of food on his shirt.</p> <p>13. Review of resident 74's EMR revealed he admitted to the facility on 7/30/21. His 2/9/26 BIMS assessment score was 00, which indicated his cognition was severely impaired. His 3/25/26 care plan indicated that his speech was unclear at times but usually understood others and was usually able to be understood. He was dependent upon the staff for his personal hygiene, oral hygiene, and dressing.</p> <p>Resident 74's CNA task documentation and nurse progress notes did not indicate on 3/24/26 or 3/30/26 that he refused having his clothing changed or his face and hands washed.</p> <p>14. Interview on 3/31/26 at 8:32 a.m. with registered nurse (RN) T revealed she expected the staff to offer to change a resident's clothing if it became soiled, but that the resident could refuse. If a resident refused to have their clothing changed, she expected the refusal to be documented in that residents EMR. She expected a resident's hands and face to be washed when they became soiled. Resident 74 required assistance from the staff to wash his face and hands and change his clothing. Resident 74 had refused his clothing being changed at times but had allowed them to be changed other times.</p> <p>15. Interview on 3/31/26 at 8:56 a.m. with restorative aid (RA) PP revealed residents' clothing was to be changed when it was dirty. A resident's face and hands should be washed after meals and any time they were soiled. Resident 74 allowed staff to change his clothes and wash his hands and face if they asked him.</p> <p>She felt it was undignified treatment when residents did not get their clothing changed or their hands and face washed when they were soiled. She thought that resident 74 often was not assisted by the staff to change his clothing or wash his face and hands when they were soiled and stated that happened to other residents as well.</p> <p>16. Interview on 3/31/26 at 10:45 a.m. with director of nursing (DON) B revealed she expected the staff to change a resident's clothing and wash their hands and face when they were soiled. If the resident refused to have their clothing changed or their face and hands</p>	F0550		

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F0550 SS = D	<p>Continued from page 6 washed, she expected the CNA to document the resident's refusal and notify the resident's nurse so she could document the resident's refusal.</p> <p>17. Observation on 3/24/26 at 2:55 p.m. of CNAs N and Q in resident 3's room revealed they each put on a pair of gloves and then placed a gait belt (a waist strap gripped as support for safe mobility and transfers) around resident 3's waist. They assisted him to stand at the sink, lowered his pants, removed his incontinence brief, cleaned his private areas with a wet wipe, and put a new incontinence brief on the resident.</p> <p>Resident 3's roommate was lying in his bed at that time. The privacy curtain was not pulled far enough to prevent the roommate from seeing resident 3 during the observed personal care above, and the window blinds were open.</p> <p>18. Interview on 3/25/26 at 10:59 a.m. with CNA/staffing coordinator AA revealed that resident 3 should have been changed while lying in his bed or standing by his bed, with the privacy curtain pulled, and out of view of the window.</p> <p>19. Interview on 3/31/26 at 1:05 p.m. with DON B revealed that she expected resident 3 to be changed in bed or in an area where he could not be seen by others. She acknowledged that the above observation did not provide him with dignity or privacy.</p> <p>20. Review of resident 3's EMR revealed his 3/12/26 BIMS assessment score was 2, which indicated his cognition was severely impaired. He had diagnoses of depression (persistent sadness, low energy, and loss of interest in activities) and anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability).</p> <p>His 2/18/26 care plan indicated he had a severe mental illness with a risk for abuse and neglect.</p> <p>21. Review of the provider's 11/18/25 Resident Dignity and Privacy policy revealed that the facility was to "protect and promote resident rights and treat each resident with respect and dignity, as well as, care for each resident in a manner and in an environment, that</p>	F0550		

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F0550 SS = D	Continued from page 7 maintains resident privacy. "Groom and dress residents according to resident preference. Clothing should be changed when soiled. Document any resident refusals." Privacy was to be provided to residents when assisting them with their personal care. And the doors, window blinds, and divider curtains were to be closed to provide privacy.	F0550		
F0561 SS = E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, record review, and policy review, the provider failed to support the residents' right to choose and receive the frequency of bathing consistent with their preferences	F0561	1. Residents #16, #36, #61, and #77 bathing preferences were reviewed and scheduled per their preference. Baths/showers will be provided by residents' preference. Resident #16, #36, #61 and #77 care plans were updated to reflect residents' preferences. 2. All residents are at risk for deficient practice. A review of all residents will be completed comparing bathing preferences, schedules, documentation, and care plans to ensure resident choices are accommodated. 3. Root Cause Analysis: The staff assigned to provide baths were not following resident bathing preferences and lack of management oversight in the process of care delivery of bathing schedules, bathing refusals, and documentation of refusals. All bathing schedules and care plans will be reviewed and revised to reflect bathing preferences. DON or designee to complete all caregiver staff education on honoring bathing preferences and documenting bath refusals with reapproach per facility bathing policy to be completed no later than 05/08/26. Those not in attendance at education sessions will be educated prior to their next shift worked. 4. DON or designee will review missed bath alerts report daily for residents' bathing refusals and missed bathing documentation. DON or designee will audit 5 resident's bathing preferences through resident interviews and care plan reviews weekly x 6 weeks, then monthly x 2 months. DON or designee will audit bathing documentation for missed and refused bathing and follow-up for 5 residents weekly x6 weeks, then monthly x2 months. DON or Designee will	05/08/2026

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F0561 SS = E	<p>Continued from page 8 for four of thirty-four sampled residents (16, 36, 61, and 77) who preferred to receive bathing at least twice a week.</p> <p>Findings include:</p> <p>1. Review of the provider's 3/17/26 SD DOH FRI regarding resident 16 revealed resident 16's family member reported concerns related to the staff not providing resident 16 routine bathing.</p> <p>Administrator A indicated in the 3/17/26 FRI that resident 16 received a bath on 3/9/26 and 3/16/26 and was provided an additional bath on 3/17/26 at the request of resident 16's family member.</p> <p>2. Review of resident 16's electronic medical record (EMR) revealed she admitted to the facility on 3/2/26. Her Brief Interview of Mental Status (BIMS) assessment score was 4, which indicated her cognition was severely impaired.</p> <p>Her 3/25/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated she preferred to have a shower or bath two times a week.</p> <p>The 1/28/26 through 3/25/26 bathing documentation for resident 16 indicated she received a bath on 3/9/26, refused her bath on 3/13/26, received a bath on 3/16/26 and was not available for a bath on 3/20/26. There was no documentation that she received or was offered bathing on 3/23/26.</p> <p>Resident 16's 3/20/26 progress note indicated there was no documentation that resident 16 was out of the facility or any other reason she was unavailable for her bath that day.</p> <p>3. Interview on 3/30/26 at 2:08 p.m. with resident 16's family member revealed that staff provided her mother one shower since she admitted to the facility on 3/2/26 and when she expressed her concerns about the care her mother received on 3/17/26.</p> <p>4. Interview on 3/24/26 at 1:51 p.m. with resident 36 revealed there were times when he did not receive a bath for a week. He stated he had to repeatedly remind the staff that he needed a bath before he would get his bath. The days of the week which he was given his bath</p>	F0561	present audit findings monthly in QAPI meeting for progress review and recommendations.	

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F0561 SS = E	<p>Continued from page 9 were not consistent. At times he would wait a week between his baths and other times his baths were every other day.</p> <p>5. Review of resident 36's EMR revealed he admitted to the facility on 11/19/25. His 2/25/26 BIMS assessment score was 12, which indicated his cognition was moderately impaired. His 3/25/26 care plan indicated he preferred to receive a shower or a bath two times per week.</p> <p>The bathing documentation from 1/28/26 through 3/25/26 for resident 36 indicated he was to be provided baths or showers two times a week on Wednesdays and Saturdays. He was scheduled to receive a bath or shower on January 28 and January 31; February 4, 7, 11, 14, 18, 21, 25, and 28; and March 4, 7, 11, 14, 18, and 21. There was no documentation that he refused to bathe or shower.</p> <p>Before his shower on 2/21/26, it was seven days since he had received a bath or shower and before his shower on 3/13/26, it was six days since he had received a bath or shower.</p> <p>6. Interview on 3/24/26 at 2:00 p.m. with resident 61 revealed he did not receive the showers that he was supposed to. He was scheduled for a shower on 3/24/26 but he stated he did not know if he was going to receive a shower that day.</p> <p>7. Review of resident 61's EMR revealed he admitted to the facility on 11/19/25 and his 2/25/26 BIMS assessment score was 15, which indicated his cognition was intact. His 3/25/26 care plan indicated he preferred to receive a shower or a bath two times per week.</p> <p>The bathing documentation from 1/28/26 through 3/25/26 for resident 61 indicated he was to be provided baths or showers two times a week on Tuesdays and Fridays. He did not receive a bath or shower on 2/13/26, 3/3/26, 3/6/26, and 3/17/26. There was no documentation that he refused to bathe or shower.</p> <p>Between 2/10/26 and 2/17/26 resident 61 was not bathed or showered for seven days, between 2/27/26 and 3/10/26 he was not bathed or showered for ten days, and between 3/13/26 and 3/20/26 he was not bathed or showered for seven days.</p>	F0561		

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F0561 SS = E	<p>Continued from page 10</p> <p>8. Observation and interview on 3/24/26 at 2:48 p.m. with resident 77 revealed he had long jagged fingernails and smelled like urine. He wanted his showers on Sundays and Thursdays but there were times he did not receive his shower on his scheduled day, or the day was changed. He stated there were times when the staff told him he was not going to get a shower because the shower was being repaired.</p> <p>9. Review of resident 77's EMR revealed he was admitted to the facility on 11/28/28. His 2/20/26 BIMS assessment score was 10, which indicated his cognition was moderately impaired, and his 3/24/26 care plan indicated he preferred to shower two to three times a week.</p> <p>Resident 77's shower documentation from 1/28/26 through 3/25/26 indicated he was to be provided a shower twice weekly on Sundays and Thursdays. He did not receive a shower on 1/29/26, 2/26/26, 3/5/26, and 3/19/26. There was no documentation that he refused to bathe or shower.</p> <p>Between 1/25/26 and 2/1/26 resident 77 did not bathe for six days, between 2/22/26 and 3/1/26 he did not bathe for six days, between 3/1/26 and 3/8/26, he did not bathe for six days, and between 3/15/26 and 3/22/25 he did not bathe for six days.</p> <p>10. Review of the provider's undated Center Hall Bath Schedule revealed that resident 77 was scheduled to receive bathing on Sundays and Thursdays, resident 16 was scheduled to receive bathing on Mondays and Fridays, resident 61 was scheduled to receive bathing on Tuesdays and Fridays, and resident 36 was scheduled to receive bathing on Wednesdays and Saturdays.</p> <p>11. Review of the provider's grievance log from November 2025 through March 2026 revealed on 11/19/25 four residents brought forward a concern of not having received their baths or showers. On 1/21/26 during a resident council meeting the residents expressed their concern about not having received their baths.</p> <p>On 3/6/26 residents 28 and 92 filed grievances because they were not receiving their baths. On 3/18/26 during a resident council meeting the residents indicated they wanted a designated bath aide to give them their baths and showers. The resolution indicated, "Educated [the] residents in [the] resident council [meeting] on why</p>	F0561		

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F0561 SS = E	<p>Continued from page 11</p> <p>[a] bath aide hasn't worked in the past, reviewed [the] resident's baths and they are receiving [their] baths, refusals [were] documented."</p> <p>12. Interview on 3/25/26 at 10:00 a.m. with the resident council revealed there were eleven residents present during the interview and seven residents expressed concerns related to bathing.</p> <p>They said that the baths were not completed as scheduled. They were told by the CNA that was supposed to given them their bath that they were being skipped because there were other residents who had waited longer for their bath. They were told in resident council a bath aide was hired to give them their baths, but that did not last. They were told that they were "short-staffed" and the staff could not give the residents their baths.</p> <p>One resident said she had waited eight days to get a bath, another resident thought she previously waited two weeks between her baths, a third resident stated it was two weeks since his last bath because the chair he needed broke and was not fixed or replaced, and another resident stated he had one bath in three weeks and his preference was two baths per week.</p> <p>The residents stated they felt the provider worked on the issues they brought to the resident council meetings but then the issues returned after they were provided a resolution during resident council.</p> <p>13. Interview on 3/31/26 at 8:32 a.m. with registered nurse (RN) T revealed she had received residents' complaints related to not receiving their baths as they were scheduled. There were times when leadership asked staff to come in to work an extra shift to attempt to get the residents bathed.</p> <p>If a resident refused a bath, she expected the CNA to reapproach that resident for their bath later. If that resident continued to refuse their bath, the CNA should document that resident's refusal in their EMR.</p> <p>She acknowledged that the residents not receiving their baths as scheduled could potentially contribute to odors, dignity concerns, and skin breakdown.</p> <p>RN T did not know how to determine what the residents' scheduled baths were or what each resident's bathing frequency preference was. She stated the residents' bathing schedule used to be on the pocket care plan (a</p>	F0561		

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F0561 SS = E	<p>Continued from page 12 document that identifies residents' care needs and interventions) but it was no longer there.</p> <p>14. Interview on 3/31/26 at 8:56 a.m. with restorative aide (RA) PP revealed she gave residents' their baths when she worked as a CNA. She stated residents had complained to her about not receiving their baths as often as they preferred. The residents' baths were not completed as they were scheduled. There were times a resident may not be provided with a bath for more than one week. She acknowledged that the residents not receiving their scheduled baths had the potential to contribute to odors, skin conditions, and could impact that resident's dignity.</p> <p>The identified bathing preferences were in each resident's care plan, and the baths were scheduled on a bath schedule form.</p> <p>The CNAs working with the residents who were scheduled for a bath on that day were responsible for assisting those residents with their bathing. There were two bathing rooms on the long-term care side of the facility and one bathing room for the short-term rehabilitation residents.</p> <p>15. Interview on 3/31/26 at 10:45 a.m. with director of nursing (DON) B revealed she expected the residents to be bathed according to the residents' identified preferences in their care plans. The provider did not have a designated bath aid, the CNA responsible for the resident who was scheduled to have a bath that day would give that resident their bath.</p> <p>If a resident refused their bath, she expected that refusal to be documented in the resident's EMR.</p> <p>She was aware there were grievances brought forward during the resident council meeting several months ago related to residents not receiving their preferred bathing frequency. She felt the issue related to residents receiving their baths according to their identified preferences had improved.</p> <p>Each morning the facility's leadership staff reviewed any EMR triggered alerts related to bathing, which included if a bath was not given as scheduled.</p> <p>16. Interview on 3/31/26 at 1:41 p.m. with administrator A revealed she had spoken with resident 16's family member about her concerns related to</p>	F0561		

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F0561 SS = E	Continued from page 13 resident 16's bathing and felt she was not receptive to the explanation of the cares that were provided to resident 16. She expected the staff to follow the residents' care plans while they attended to each resident's care needs. Administrator A did not know why resident 16 was documented to be unavailable for her bath on 3/20/26. There was no additional information documented in the EMR about that. 17. Review of the provider's 5/14/25 Bathing policy revealed "The purpose of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. The resident has the right to choose timing and frequency of bathing activity." "Document bathing activity or refusal of the bathing activity. If [the] resident refuses bathing, reapproach [the] resident at a later time or offer another day to bathe the resident."	F0561		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §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. §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. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (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. (ii) This includes a written description of the facility's policies to implement advance directives and	F0578	1. Residents #2 and #25 code status verified with physician, resident and/or responsible party. EMR banner, physician orders, care plan and signed forms reconciled to ensure they match the resident's wishes. 2. All residents are at risk for deficient practice. A review of all residents will be completed to reconcile EMR banner, physician orders, care plan and signed code status forms to ensure they match the resident's wishes. 3. Root Cause Analysis: The facility lacked a standardized system to cross check advance directives with assigned accountability to ensure consistency of advance directives. A new standardized reconciliation process was initiated and implemented to be completed at residents' admission, readmissions, quarterly, and with any status change to be monitored by administrator or designee. Pocket care plans must match EMR and signed documents and are to be reviewed at admission, re-admission, quarterly and with any status change.	05/08/2026

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F0578 SS = D	<p>Continued from page 14 applicable State law.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>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 two of two sampled residents (2 and 25) was currently and accurately documented in the residents' electronic medical records (EMR).</p> <p>Findings include:</p> <p>1. Review of resident 25's EMR revealed she admitted to the facility on 3/5/24. A banner located at the top of her EMR indicated her code status was "Full code [to start life-sustaining measures if one's heart or breathing stopped]-cardiac resuscitation [chest compressions and/or rescue breathing, also known as CPR] but no intubation [the insertion of a tube into the windpipe to maintain an open airway]."</p> <p>There was a 2/4/26 physician's order for "Full code-cardiac resuscitation but no intubation."</p> <p>Resident 25's 3/8/24 signed code status form was signed by resident 25 on 3/8/24 and the physician on 3/13/24. That form indicated her wishes were "Do Not Resuscitate" [no life-sustaining measures if one's heart or breathing stops, also known as DNR]. There were no other signed code status forms in resident 25's EMR.</p> <p>The provider's undated pocket care plan (a paper reference used by staff to identify a resident's basic</p>	F0578	<p>Any discrepancies with code status will be re-evaluated at time of identification with resident and/or responsible party for clarification by DON or designee. The administrator, DON, and interdisciplinary team, in collaboration with the medical director, will review, revise, and/or create policies and procedures that address the residents' right to formulate advance directives, including choosing to accept or refuse treatment and choosing to receive or not receive life-sustaining measures (code status), and the various steps necessary to promote and implement these rights, including but limited to ongoing reviews and accurate documentation of those choices. Education and training will be provided to all staff on their roles and responsibilities regarding residents' rights related to advance directives and choices. Competencies of staff knowledge and implementation of all aspects of the education provided will be conducted by 05/08/2026. Those not in attendance at education sessions will be educated prior to their next shift worked.</p> <p>4. Administrator or designee will audit all new admissions and any Advance Directive order changes for accuracy weekly x 6 weeks, then monthly x 2 months. Administrator or Designee will present audit findings monthly in QAPI meeting for further progress review and recommendations.</p>	

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F0578 SS = D	<p>Continued from page 15 care needs) for resident 25 indicated she was a "Full Code".</p> <p>2. Review of resident 2's EMR revealed she admitted to the facility on 12/31/25 and admitted again on 2/19/26 after a hospitalization from 1/29/26 through 2/19/26. A banner located at the top of her EMR indicated her code status was "DNR: OK to intubate". There was a 2/19/26 physician's order that stated "DNR: OK to intubate".</p> <p>On 2/10/26 resident 2 and a medical provider signed a "Resuscitation Designation Order" that indicated resident 2 wanted to be a DNR. There was no documentation on that form that indicated she wished to be intubated.</p> <p>The provider's undated pocket care plan for resident 2 indicated she was a "Full Code".</p> <p>3. Interview on 3/26/26 at 10:15 a.m. with certified nursing assistant (CNA)/certified medication aide (CMA) V revealed she referenced the Kardex (a report of the resident's care needs and interventions) within the resident's EMR or their pocket care plan.</p> <p>The nurse managers were responsible for updating the pocket care plan for their code status. The pocket care plans were not always up to date. If she noticed a pocket care plan was not up to date, she would notify the nurse manager that it needed to be updated.</p> <p>CNA/CMA V referenced resident 2 and 25's pocket care plans and stated they indicated both residents' code status was listed as full code.</p> <p>4. Interview and EMR review on 3/30/26 at 3:46 p.m. with licensed practical nurse (LPN) O revealed a resident's code status was found on their EMR banner. If the identified code status displayed on the EMR screen was "clicked on" it would access that resident's written code status form.</p> <p>LPN O stated she would reference the resident's code status on the EMR banner or the resident's pocket care plan. She reviewed resident 2's and 25's EMR banners, signed code status forms, and their pocket care plans and verified that both residents' code statuses were not the same within those three areas.</p> <p>LPN O acknowledged that the differences between the residents' EMR banners, signed code status form, and</p>	F0578		

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F0578 SS = D	<p>Continued from page 16</p> <p>their pocket care plans posed a risk that those residents' wishes may not be followed if they had a medical emergency and were unresponsive.</p> <p>5. Interview on 3/31/26 at 10:45 a.m. with director of nursing (DON) B revealed the nurse managers and the social services staff were responsible for documenting the residents' code statuses on the written code status form and in that resident's EMR.</p> <p>6. Interview on 3/31/26 at 1:41 p.m. with administrator A revealed the nurse manager reviewed the residents' wishes related to their code status when they admitted to the facility.</p> <p>The nurse manager would document the resident's desired code status on the written code status form, the resident or the resident's representative would sign the code status form, and then the form would be sent to the physician to be signed. The nurse manager entered the resident's desired code status into that resident's EMR banner.</p> <p>The resident's code status was to be reviewed with the resident or the resident's representative quarterly and updated as needed.</p> <p>Administrator A acknowledged that resident 2's and resident 25's code statuses were not consistent between their signed code status forms, the EMR banners, and the pocket care plans, which had the potential for the residents' wishes to not be followed if their heart or breathing stopped.</p> <p>7. Review of the provider's 5/14/25 Advanced Directive policy revealed it was the policy of the facility "for each resident to choose their Advanced Directives upon admission and such may be changed by the resident at any time during their stay."</p> <p>"An Advanced Directive for (as provided by the healthcare facility) shall be completed with [the] resident and/or legal representative to verify treatment options as well as code status."</p> <p>"The resident's Advanced Directive choices/options shall be reviewed with [the] resident/resident representative during quarterly and significant change assessment and care planning."</p>	F0578		
F0600 SS = D	Free from Abuse and Neglect	F0600		

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F0600 SS = D	<p>Continued from page 17</p> <p>CFR(s): 483.12(a)(1)</p> <p>§483.12 Freedom from Abuse, Neglect, and Exploitation</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on South Dakota Department of Health (SD DOH) Facility Reported Event (FRI) report, interview, record review, observation, and policy review, the provider failed to protect the resident's right to be free from neglect for one of one sampled resident (15) who was left in the dining room for approximately 10 hours by one of one certified nursing assistant (CNA) (RR) and one of one licensed practical nurse (LPN) (SS) without receiving identified interventions to meet his care needs.</p> <p>Findings include:</p> <p>1. Review of the 11/8/25 SD DOH FRI report revealed that on 11/8/25 at around 10:00 p.m., CNA AA notified director of nursing (DON) B that resident 15 was left in the dining room without being changed. Upon camera review, resident 15 was brought out to the dining room around 8:30 a.m. and was not taken back to his room until 6:31 p.m. The report indicated that resident 15 had a urinary catheter (flexible tubing placed in the bladder to drain urine), was able to move around in his wheelchair, readjust himself in his wheelchair, was forgetful and needed the staff to assist him with using the bathroom. His skin was assessed, and he did not have skin breakdown related to the incident. He was not incontinent of his bowels. When interviewed, resident 15 indicated he felt safe at the facility. CNA RR and LPN SS were responsible for providing his care needs that day (11/8/25). CNA RR's employment with the</p>	F0600	<ol style="list-style-type: none"> 1. Resident #15 was assessed with no adverse outcomes identified. Resident #15's care plan was reviewed and updated to reflect to transfer the resident from the dining room after meals and to offer assistance with care needs. 2. All residents are at risk for deficient practice. An initial review of all residents will be conducted focusing on assisting residents from the dining room after meals to offer assistance with care needs by 05/08/2026. 3. Root Cause Analysis: The facility lacked a system of rounding in dining and common areas to ensure all resident needs were met. Administrator or Designee will complete all staff education on abuse/neglect policies and expectations regarding assisting residents out of the dining room after meals to be completed no later than 05/08/2026. Those not in attendance at education sessions will be educated prior to their next shift worked. 4. Administrator or Designee will complete dining room and common area rounding to ensure no residents remain in the dining room unattended for extended periods of time, daily x 2 weeks, then weekly x4 weeks, then monthly x2 months. Administrator or designee will conduct abuse and neglect focused resident interviews for 5 random residents weekly x 6 weeks, then monthly x 2 months. Administrator or Designee will present audits monthly in QAPI meeting for further review progress and recommendations. 	05/08/2026

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F0600 SS = D	<p>Continued from page 18 facility was terminated, and LPN SS was educated and returned to work after the investigation was completed. To prevent similar incidents from occurring, the facility reminded all staff to ensure that residents were taken out of the dining room between meals to have their cares completed, audits to ensure residents were not left in the dining room between cleans to receive cares were to be completed every four weeks and then monthly for two months, and all staff were educated about the provider's abuse and neglect policy.</p> <p>2. Interview on 3/25/25 at 8:45 a.m. with resident 15 revealed that he did not answer questions appropriately and smiled.</p> <p>3. Review of resident 15's electronic medical record (EMR) revealed he admitted to the facility on 12/6/24. His 12/31/25 Brief Interview for Mental Status (BIMS) assessment score was 1, which indicated his cognition was severely impaired.</p> <p>He had diagnoses of metabolic encephalopathy (a decline in brain function related to a chemical imbalance in the body) and dementia (a group of symptoms affecting memory, thinking, and social abilities).</p> <p>He had a 4/3/25 physician's order to receive Donepezil 10 milligrams (mg) daily (a medication for dementia).</p> <p>Resident 15's 1/5/26 care plan indicated he was at risk for skin impairment related to his Braden score (a tool used to assess the risk of developing pressure ulcers) and a history of having a stage II (open wound or blister with partial-thickness skin loss) pressure ulcer to his right buttock and left foot. He was to be repositioned by staff every two hours and as needed, to prevent skin damage.</p> <p>He had a urinary catheter and was at risk for urinary infections. His urine output was to be documented every shift, typically after each emptying.</p> <p>He required substantial assistance from staff with completing his toileting hygiene care every two to three hours, transferring, and with his wheelchair mobility. He had a risk for falling, he required extensive care, and his "care needs would be provided</p>	F0600		

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F0600 SS = D	<p>Continued from page 19 during his stay at the facility".</p> <p>Resident 15 would "be treated with respect, dignity, and reside in the facility free of mistreatment."</p> <p>4. Observations of resident 15 and other residents during the survey process from 3/24/26 through 3/26/26 and 3/30/26 through 3/31/26 revealed that residents were not left in the same area for prolonged periods of time.</p> <p>5. Interviews completed with direct care staff during the survey process indicated that they received education to not leave the residents in an area for a prolonged period of time without care being provided.</p> <p>6. Interview on 3/31/26 at 12:24 p.m. with registered nurse (RN) T revealed she monitored the resident's care provided by the staff, and she would document in the resident's EMR that scheduled repositioning was completed for the residents who needed to be repositioned.</p> <p>7. Interview on 3/31/26 at 12:27 p.m. with CNA TT revealed that if he saw a resident sitting in the same area for a prolonged period without care he would notify the nurse.</p> <p>8. Interview on 3/31/26 at 12:29 p.m. with dietary aide GG revealed that she would notify the nurse to assist residents who needed help if they were left in the dining room for a prolonged period.</p> <p>9. Interview on 3/30/26 at 4:00 p.m. with DON B revealed the provided list of staff who were educated about the abuse and neglect policy did not include all of the facility staff.</p> <p>10. Interview on 3/31/26 at 9:25 a.m. and 1:05 p.m. with DON B revealed that the facility's investigation of the above incident determined that resident 15 was neglected by the staff because CNA RR did not follow his care plan and did not provide him care for approximately ten hours. CNA RR's employment with the facility was terminated.</p>	F0600		

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F0600 SS = D	Continued from page 20 She could not find documentation that all staff were educated on the abuse and neglect policy after the 11/8/25 incident, as was indicated in the provider's final investigation report to the SD DOH. 11. Review of the provider's 5/14/25 Abuse and Neglect policy revealed "It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse,...neglect, or mistreatment." It defined neglect as "the failure to provide necessary and adequate (medical, personal or psychological) care. Neglect is the failure to care for a person in a manner, which would avoid harm and pain, or the failure to react to a situation which may be harmful. Staff may be aware or should have been aware of the service the resident requires but fails to provide that service." Employees were to be trained on abuse and neglect during orientation and to have annual continuing education.	F0600		
F0641 SS = E	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification.	F0641	1. Resident #2, #8, #36, #41, #49's MDS assessments were reviewed, corrected and submitted for accuracy regarding PASRR, Insulin use, and Psychotropic medications. 2. All residents are at risk for deficient practice. A review of MDS assessments completed in past 30 days for PASRR, insulin and psychotropic medication coding accuracy will be completed. 3. Root Cause Analysis: The facility lacked a system for ensuring assessments, care plans and documentation were consistent for accuracy with MDS and lacked appropriate education on coding PASRR appropriately on the MDS. A new MDS Accuracy monitoring process was initiated and implemented to be completed prior to MDS submission by MDS coordinator or designee. Administrator or designee will educate MDS coordinators and Social Services staff on MDS accuracy with supporting documentation requirements by 05/08/2026. Those not in attendance at education sessions will be educated prior to their next shift worked.	05/08/2026

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F0641 SS = E	<p>Continued from page 21</p> <p>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review, interview, and Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 review, the provider failed to ensure five of six sampled residents' (2, 8, 36, 41, and 49) Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessments were accurately coded for the areas of Pre-Admission Screening and Resident Review (a mandatory federal process that ensures people with mental illness or intellectual disabilities are not inappropriately placed in nursing homes)(PASRR), insulin administration, and prescribed psychotropic medications (drugs that affect brain activities associated with mental processes and behavior).</p> <p>Findings include:</p> <p>1. Review of resident 8's electronic medical record (EMR) revealed he admitted to the facility on 4/11/24 and had an approved PASRR Level II on 12/6/24. His 9/3/25 comprehensive MDS assessment indicated he did not have a PASRR Level II, and his PASRR Level II was added to his care plan on 2/2/26.</p> <p>His 3/6/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact.</p> <p>He had diagnoses of depression (persistent sadness, low energy, and loss of interest in activities), bipolar disorder with psychotic features (extreme mood swings, mania or depression, accompanied by a temporary break from reality), and anxiety (anticipation of future danger or misfortune with feelings of distress and/or</p>	F0641	4. Administrator or Designee will complete weekly audits for MDS accuracy related to PASRR, insulin and psychotropic medications x 6 weeks, then monthly x 2 months. Administrator or designee will present audit findings monthly in QAPI meeting for progress review and recommendations	05/08/2026

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F0641 SS = E	<p>Continued from page 22 sadness and symptoms such as restlessness or irritability). He did not have a physician's order to take any medications for those diagnoses.</p> <p>2. Review of resident 49's EMR revealed she admitted to the facility on 5/28/24 and had an approved PASRR Level II on 8/28/25. Her 9/26/25 comprehensive MDS assessment indicated she did not have a PASRR Level II, and her PASRR Level II was added to her care plan on 2/1/26.</p> <p>Her 3/5/26 BIMS assessment score was 15, which indicated her cognition was intact.</p> <p>She had diagnoses of major depressive disorder and generalized anxiety disorder, a 1/9/26 physician's order for Sertraline (a depression medication).</p> <p>3. Interview on 3/26/26 at 12:45 p.m. with social services designee (SSD) E revealed that she entered resident information regarding PASRRs on the MDS assessments, and she should have entered that resident 8 and resident 49 had a PASRR Level II (an in-depth evaluation required by federal law for anyone applying to a Medicaid-certified nursing home who is suspected of having a serious mental illness or an intellectual/developmental disability).</p> <p>4. Interview on 3/30/26 at 2:05 p.m. with director of nursing (DON) B revealed she expected the MDS to indicate a resident had a PASRR Level II if they had one.</p> <p>5. Interview on 3/24/26 at 1:51 p.m. with resident 36 revealed he was being administered a long-acting insulin one time per day and a short-acting insulin with each meal.</p> <p>6. Review of resident 36's EMR revealed he admitted on 11/19/25.</p> <p>His 2/25/26 BIMS assessment score was 12, which indicated his cognition was moderately impaired.</p> <p>He had a 2/5/26 physician's order for Aspart insulin (a short acting insulin) three times a day with meals and Glargine insulin (a long-acting insulin) one time a day for diabetes (a condition involving disruptions in how the body regulates blood sugar).</p>	F0641		

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F0641 SS = E	<p>Continued from page 23</p> <p>Item N0350 of his 3/6/26 quarterly MDS assessment was coded as he had not received insulin injections during the seven-day look-back period (the time period over which the resident's condition or status is captured by the MDS assessment) of that MDS assessment.</p> <p>7. Review of resident 2's EMR revealed she admitted to the facility on 12/31/25.</p> <p>She had a physician's order for trazadone (an antidepressant medication) to be given at bedtime for depression and escitalopram (an antidepressant medication) to be given one time a day for anxiety.</p> <p>She did not have a physician's order for an anti-anxiety medication.</p> <p>Item N0415 of her 1/16/26 and 3/6/26 quarterly MDS assessments were coded as she had received an anti-anxiety medication during the seven-day look back period of those MDS assessments.</p> <p>8. Review of resident 41's EMR revealed she admitted to the facility on 3/7/24.</p> <p>She had a 9/25/24 physician's order for Rexulti (an antipsychotic medication) once daily for behaviors related to Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions).</p> <p>Item N0415 of her 8/26/25 and 12/1/25 quarterly MDS assessments were coded as she did not receive an antipsychotic medication during the seven-day look back period of those MDS assessments.</p> <p>9. Interview and EMR review on 3/31/26 at 9:42 a.m. with minimum data set (MDS)/registered nurse (RN) D revealed she was responsible for the accurate submission of the residents' MDS assessments.</p> <p>She verified resident 2 was not prescribed an anti-anxiety medication but her 1/16/26 and 3/6/26 MDS assessment was coded as she had received anti-anxiety medications.</p> <p>She verified resident 36 was administered insulin four times a day since 2/5/26, but his 3/6/26 MDS assessment indicated he did not receive insulin which was inaccurate.</p>	F0641		

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F0641 SS = E	<p>Continued from page 24</p> <p>She verified resident 41 took an antipsychotic medication since 9/25/24, but her 8/26/25 and 12/1/25 MDS assessment did not indicate she had taken an antipsychotic medication, which was inaccurate.</p> <p>10. Interview on 3/31/26 at 10:45 a.m. with director of nursing (DON) B revealed she supervised the MDS nurses and she expected the residents' MDS assessments to be coded accurately.</p> <p>11. Review of the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 revealed that when answering the N0350 question related to a resident's use of insulin the number of days during the seven day look back period that the resident received an insulin injection was to be entered for N0350A.</p> <p>When coding medications within N0415 they are to be coded "according to the medication's therapeutic category and/or pharmacological classification, not how it is used."</p> <p>"Any medication that has a pharmacological classification or therapeutic category of antipsychotic medication must be recorded in this section, regardless of why the medication is being used."</p> <p>Residents suspected of having MI may require certain care and services provided by the nursing home or the state. When answering the PASRR question on the MDS assessment, question A1500 should be coded as a yes if the resident had a PASRR Level II, which would then require question A1510 to be answered to indicate the reason for PASRR Level II, "Serious mental illness, Intellectual Disability, or Other related conditions".</p> <p>12. Review of the provider's 5/14/25 PASRR policy revealed "the Preadmission Screening and Resident Review (PASRR) is a federal requirement to ensure the Nursing Facility (NF) residents with Serious Mental Illness (SMI) or Intellectual and Developmental Disability (ID/DD) are identified and evaluated, placed in the most appropriate and least restrictive setting available, transitioned to an appropriate community setting when they no longer meet criteria for NF placement, and to provide with the MI/ID/DD services they need, including specialized services."</p>	F0641		
F0655 SS = E	Baseline Care Plan	F0655		

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F0655 SS = E	<p>Continued from page 25</p> <p>CFR(s): 483.21(a)(1)-(3)</p> <p>§483.21 Comprehensive Person-Centered Care Planning</p> <p>§483.21(a) Baseline Care Plans</p> <p>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-</p> <p>(i) Be developed within 48 hours of a resident's admission.</p> <p>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-</p> <p>(A) Initial goals based on admission orders.</p> <p>(B) Physician orders.</p> <p>(C) Dietary orders.</p> <p>(D) Therapy services.</p> <p>(E) Social services.</p> <p>(F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission.</p> <p>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident.</p> <p>(ii) A summary of the resident's medications and dietary instructions.</p>	F0655	<p>1. The baseline care plans for #2, #6, #30, #36, #44, #61, #98 could not be corrected. The care plans were reviewed and updated to reflect current needs for residents #2, #6, #30, #36, #44, #61, #98. Residents #2, #6, #30, #36, #44, #61, #98 and/or their representatives will be offered a copy of baseline care plan.</p> <p>2. All residents are at risk for deficient practice. All admissions within the past 60 days will be reviewed for baseline care plan completion and copies of those care plans offered to the residents and/or their representatives.</p> <p>3. Root Cause Analysis: The facility lacked a system to ensure baseline care plans were completed within 48 hours of admission that a copy was offered to the resident and/or the resident's representative, and that the offer was documented. Administrator or designee will educate all staff on baseline care plan policy, baseline care plans to be completed within 48 hours of admission and copies are to be offered to resident and/or the resident's representative. Those not in attendance at education sessions will be educated prior to their next shift worked.</p> <p>4. Administrator or designee will audit all new admissions for baseline care plan completion and copies offered to the resident and/or the resident's representative within 48 hours of the resident's admission to the facility daily x 6 weeks, then monthly x 2 months. Administrator Designee will present audit findings monthly in QAPI meeting for progress review and recommendations.</p>	05/08/2026

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F0655 SS = E	<p>Continued from page 26</p> <p>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</p> <p>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, record review, and policy review, the provider failed to ensure the resident's baseline care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was completed within 48 hours of the resident's admission to the facility for three of nine sampled residents (2, 6, and 98), and was reviewed with, and a copy was offered to the resident or the resident's representative within 48 hours of the resident's admission to the facility for seven of nine newly admitted sampled residents (2, 6, 30, 36, 44, 61, and 98).</p> <p>Findings include:</p> <p>1. Interview on 3/24/26 at 9:22 a.m. with resident 44 revealed that he admitted to the facility about three weeks ago. He was upset about not receiving his nitroglycerin patch heart medication, which was ordered the previous morning. He stated that he spent the entire day and night worrying that something terrible would happen to him because he was not given that medication.</p> <p>There was a meeting the second week he was at the facility, where the staff members had discussed his care, and he was provided with a copy of his care plan. He pointed to the whiteboard in his room that indicated "Care Conference 3/9/26."</p> <p>2. Review of resident 44's electronic medical record (EMR) revealed he was admitted to the facility on 3/5/26, and his 3/11/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact.</p> <p>There was an uploaded signed paper copy of his baseline care plan. It was signed by resident 44 on 3/9/26 to indicate that he had received a copy and that it was reviewed with him.</p>	F0655		

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F0655 SS = E	<p>Continued from page 27</p> <p>3. Interview on 3/24/26 at 2:00 p.m. with resident 30 revealed once she reviewed her baseline care plan she was not aware it included behavior issues. She disputed the statement in her care plan that she had a history of substance abuse and was a member of Al-Anon (a program of recovery for families and friends of alcoholics). She denied being a drug abuser, but it was in her care plan. She was not offered a copy of her care plan or her baseline care plan to review after her admission to the facility.</p> <p>4. Review of resident 30's EMR revealed she admitted to the facility on 7/28/25. Her baseline care plan was completed on 7/30/25. There was no documentation that a copy of the baseline care plan was offered to or reviewed with resident 30.</p> <p>5. Interview on 3/25/26 at 3:54 p.m. with licensed practical nurse (LPN)/unit manager C revealed that she expected all residents' baseline care plans to be initiated during their nursing admission assessment on the day of their admission to the facility. She expected each resident to receive a copy of that baseline care plan when it was reviewed with them at their 48-hour care conference. Social services designee (SSD) E was responsible for printing the care plan, providing it to the resident, and scheduling the care conference.</p> <p>She stated that resident 44 admitted to the facility on a Thursday (3/5/26), and his care conference was held on the following Monday (3/9/26). The team reviewed his care plan with him during his care conference, and she thought that resident 44 had received a copy of his care plan that day. She confirmed resident 44 did not receive his baseline care plan, and it was not reviewed with him within 48 hours of his admission to the facility.</p> <p>6. Interview on 3/26/26 at 9:52 a.m. with resident 36 revealed he did not recall anyone reviewing his baseline care plan with him or having been offered a copy of his baseline care plan after he admitted to the facility.</p> <p>He stated the physical therapy department was the only staff members who spoke with him about their plans and talked to him about his goals.</p> <p>7. Review of resident 36's EMR revealed he admitted to</p>	F0655		

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F0655 SS = E	<p>Continued from page 28 the facility on 11/19/25, and his 2/25/26 BIMS assessment score was 12, which indicated his cognition was moderately impaired.</p> <p>His baseline care plan was documented by SSD E as having been reviewed with the resident or the resident's representative on 11/21/25. There was no documentation that resident 36 or his representative was offered a copy of his baseline care plan.</p> <p>8. Review of resident 6's EMR revealed she admitted to the facility on 10/8/25, and her baseline care plan was documented by SSD K as having been reviewed with the resident or the resident's representative on 10/13/25, five days after she was admitted to the facility.</p> <p>There was no documentation that resident 6 or her representative was offered a copy of her baseline care plan.</p> <p>9. Review of resident 61's EMR revealed he admitted to the facility on 11/19/26, and his baseline care plan was documented by SSD E as having been reviewed with the resident or the resident's representative on 11/21/25. There was no documentation that resident 61 or his representative was offered a copy of his baseline care plan.</p> <p>10. Review of resident 2's EMR revealed she admitted to the facility on 12/31/25, and her baseline care plan was not "locked" to indicate it was completed until 1/6/26, seven days after she was admitted to the facility. There was no documentation that resident 2 or her representative was offered a copy of her baseline care plan.</p> <p>11. Review of resident 98's EMR revealed she admitted to the facility on 3/11/26, and her baseline care plan was documented by SSD E as having been reviewed with the resident or the resident's representative on 3/16/26, five days after she admitted to the facility. There was no documentation that resident 98 or her representative was offered a copy of her baseline care plan.</p> <p>12. Interview on 3/26/26 at 12:48 p.m. and again with SSD K regarding resident 30's baseline care plan revealed resident 30 did not agree with some items in her care plan and refused to sign it until SSD K</p>	F0655		

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F0655 SS = E	<p>Continued from page 29 clarified it. SSD K attempted to revise the resident's care plan wording without omitting needed information for the resident's approval and signature, but the resident did not agree to the care plan's content and did not sign it. SSD K confirmed there was no documentation resident 30 was offered a copy of the baseline care plan.</p> <p>13. Interview and record review on 3/31/26 at 8:46 a.m. with SSD E regarding resident 44's baseline care plan revealed that the nurse who admitted him to the facility initiated his baseline care plan on 3/5/26. SSD E added information to that care plan and scheduled his care conference to be held on 3/9/26. She printed resident 44's baseline care plan and provided him a copy at the 3/9/26 care conference when they reviewed it with him.</p> <p>She stated that when a resident would admit to the facility on a Thursday or a Friday, she would schedule the resident's conference for Monday or Tuesday of the following week. That meeting was considered the "48-hour care conference," where the care team would review the resident's care plan with the resident. She did not consider whether the weekend days should have been included when she calculated the 48 hours. She confirmed that resident 44 received his baseline care plan four days after he was admitted to the facility, and not within the 48 hours as required.</p> <p>14. Interview on 3/31/26 at 12:13 p.m. with director of nursing (DON) B revealed she expected that all the residents would be provided a copy of their baseline care plans and that those baseline care plans would be reviewed with the resident or their representative within 48 hours of their admission to the facility.</p> <p>Resident 44 did not receive his baseline care plan, nor had it been reviewed with him or his representative within 48 hours of his admission to the facility.</p> <p>15. Interview on 3/31/26 at 1:35 p.m. with administrator A revealed she knew residents were to be offered a copy of their initial care plan within 48 hours of their admission to the facility. She expected the interdisciplinary team to offer residents or their representative a copy of their initial care plan during the initial care conference.</p> <p>16. Review of the provider's 5/14/25 revised Care Plans</p>	F0655		

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F0655 SS = E	Continued from page 30 policy revealed "2. A Baseline Care Plan is started by nursing staff on the first day of admission to provide guidance to direct care givers as soon as possible after admission and completed no later than 48 hours after admission." "5. During the care conference the care plan is reviewed with the resident and/or resident's representative. A care conference sign in sheet may be utilized or the facility may list those in attendance on the LGHC Multidisciplinary Care Conference UDA. The care plan may be printed (select print with signature page) and signed by the resident or resident representative."	F0655		
F0684 SS = G	<p>Quality of Care</p> <p>CFR(s): 483.25</p> <p>§ 483.25 Quality of care</p> <p>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on South Dakota Department of Health (SD DOH) Facility Reported Incident (FRI) report, interview, record review, and policy review, the provider failed to follow professional nursing standards regarding following physicians orders timely for one of one sampled resident (112) who was not administered antibiotic medications as ordered and notifying the physician about one of one sampled resident (88), who complained of feeling dizzy after receiving dialysis (a treatment that removes waste products and excess fluid from blood when the kidneys are unable to) that the resident was not consistently administered his blood pressure medication as ordered or of his low blood pressures.</p> <p>Findings include:</p> <p>1. Review of the SD DOH FRI report revealed that the provider received orders for resident 112 for cefuroxime (antibiotic) for a urinary tract infection (UTI) on Friday, 7/11/25. The order was left on a fax machine in the front reception area over the weekend, so it was not implemented. The provider found those orders on Tuesday, 7/15/25, and that same day received</p>	F0684	<p>1. Resident #112 discharged from facility. Resident #88's physician was notified of the medication error on 03/27/26. That identified error could not be corrected. Resident #88 medication administration documentation reviewed with no further discrepancies. All facility fax machines are being checked daily to ensure orders are received and processed promptly.</p> <p>2. All residents are at risk for deficient practice. All residents with current blood pressure medication related parameters will be reviewed and any identified concerns will be addressed by 05/08/26. Physician orders from 04/01/26-04/30/26 for all residents will be reviewed for completion and any identified concerns addressed by 05/08/2026.</p> <p>3. Root Cause Analysis: The facility lacked a system to ensure all faxed orders are promptly processed, medications are administered as ordered, physician notification related to specified medication parameters and medication errors, and the staff's lack of clinical judgement to follow the change in condition policy. The administrator, DON, and interdisciplinary team, in collaboration with the medical director, will review, revise, and/or create policies and procedures that address quality of care including but not limited to following physicians' orders, administering medications as ordered, and the process and expectations for notifying the physician of any medications not administered as ordered and of a resident's change of condition,</p>	05/08/2026

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F0684 SS = G	<p>Continued from page 31 physicians' orders for a different antibiotic, nitrofurantoin, after the urine culture results were completed. On 7/15/25, resident 112 and her family requested to go to the emergency room. To prevent further instances from occurring, the provider educated all on-call managers and weekend managers to check the fax machine behind the reception desk for faxed orders and to give those orders to the respective nurses. The nurses were educated to check the main fax machine for orders throughout their shift. The physicians' offices were given updated fax machine numbers to which they should send orders to.</p> <p>2. Phone interview on 3/30/26 with resident 112's son revealed that a few days after admission to the facility, resident 112 became more confused, had back pain, and he was concerned the resident had another UTI. He requested that she have urine collected for urinary analysis (urine testing for health issues such as infections, also known as UA) collected on a Monday. He called the facility that Tuesday to see if her urine sample was collected, and was told it would be collected that afternoon. He was told by staff that on Wednesday, they had collected the sample, but it had sat in the refrigerator for too long, and it had to be recollected. The person he talked to at the nursing home said he was going to deliver it to the laboratory himself. He said the facility did not start the antibiotic that was ordered while the urine culture (UC) was pending. He was told that the resident was given a dose of a newly prescribed antibiotic on 7/15/25, before she went to the emergency room. In the emergency room, the papers that were sent by the facility indicated that the antibiotic was not given to the resident. Resident 112 was admitted to the hospital on 7/15/25 and did not go back to the nursing home, per his request. He reported he was upset about the situation, and talked to the nursing home administration about his frustrations regarding his mother's delayed care.</p> <p>3. Review of resident 112's electronic medical record revealed she admitted on 7/2/25. Her 7/3/25 Brief Interview for Mental Status (BIMS) assessment score was 11, which indicated she had moderate cognitive impairment. Her diagnoses included respiratory failure (a condition making it hard to breathe) and pneumonia (lung infection). Her 7/2/25 care plan indicated she had the potential for infection. Staff were to monitor for signs and symptoms of infection. She was at risk for altered thought process, and staff were to notify the physician if she displayed any changes in her</p>	F0684	<p>such as medication administration errors, blood pressure changes, and other potential signs of adverse effects of missed medications, for review and recommendations to ensure prompt treatment and quality of care. Education will be provided to all nursing staff about their roles, responsibilities, and assigned tasks regarding those policies and procedures. Competencies of staff knowledge and implementation of all aspects of the education provided will be conducted by 05/08/2026. Those not in attendance at education sessions will be educated prior to their next shift worked.</p> <p>4. DON or designee will continue to monitor all facility fax machines for orders received across all shifts daily. DON or designee will audit 5 residents with blood pressure medication related parameters to ensure the medication was administered as ordered and provider notification was completed as needed related to order parameters and any medication errors x 6 weeks then monthly x2 months. DON or designee will audit 5 residents for prompt implementation of new medication orders weekly x4 weeks then monthly x 2 months. DON or Designee will present audit findings monthly in QAPI meeting for progress review and recommendations.</p>	

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F0684 SS = G	<p>Continued from page 32 cognitive function or behavior. She had a urinary catheter that was to be changed per the physician's orders.</p> <p>A 7/8/25 at 4:24 a.m. progress note by registered nurse (RN) S stated that resident 112's son called with concerns that his mother was more confused, and he requested a urine sample to be collected. RN S notified the resident's physician.</p> <p>A 7/8/25 physician visit report indicated that resident 112 had increased confusion, and the physician ordered a UA.</p> <p>On 7/8/25, physician orders were received to change her urinary catheter and collect a urine sample for UA/UC. That order was noted as reviewed on 7/8/25 by licensed practical nurse (LPN) KK.</p> <p>On 7/8/25 at 11:19 a.m., a progress note by LPN KK included the resident 112's physician ordered a UA/UC.</p> <p>On 7/8/25 at 3:37 p.m., a progress note by LPN KK stated that resident 112 had been confused all day. She was supposed to wear her oxygen at a flow rate of four liters (L) per minute, but the resident refused to wear the oxygen tubing because she thought there was urine in the tubing. LPN KK educated her, and reapplied her oxygen.</p> <p>On 7/8/25 at 4:37 p.m., a progress note by LPN KK indicated that resident 112 continued to be confused. The resident was on her phone talking to a friend, and she told her friend she was going to be kicked out of the facility.</p> <p>Resident 112's treatment administration record (TAR) indicated that her catheter was to be changed prior to the UA being collected, and the catheter was scheduled to be done on 7/8/25 at 6:00 p.m. It was documented as completed on 7/9/25 at 5:23 a.m. by RN S.</p> <p>A 7/10/25 at 3:13 p.m. lab report indicated the urine sample was collected on 7/10/25 at 1:30 p.m. and received on 7/10/25 at 2:53 p.m. The report was sent to the physician, and orders were received on 7/11/25 for</p>	F0684		

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F0684 SS = G	<p>Continued from page 33 Cefuroxime antibiotic 500 mg to be given to the resident twice a day for five days. This order was not noted as reviewed by staff.</p> <p>On 7/10/25 at 4:20 p.m., a progress note by RN F indicated that lab results were received and faxed to the physician.</p> <p>A 7/11/25 lab report indicated that resident 112's urine sample was collected on 7/9/25 at 1:07 a.m. and was received on 7/10/25 at 7:39 a.m. That lab result indicated there was Enterobacter cloacae complex (type of bacteria) in more than 100,000 (Colony Forming Units per milliliter) CFU/mL (indicates the number of bacterial cells found in the test), and susceptibility (a lab report that indicates what antibiotic could be used to treat the specific infection) was to follow. This urine lab result report was noted as reviewed by LPN KK on 7/11/25.</p> <p>On 7/11/25 at 11:20 p.m. progress note by LPN KK indicated that she had notified the physician of the above lab results.</p> <p>A 7/12/25 preliminary (an early report from the lab while the sample is still being tested) UC lab report indicated that the resident's urine sample was collected on 7/10/25 at 1:30 p.m. and received on 7/10/25 at 2:53 p.m. The result indicated the urine sample had Enterobacter cloacae and contained greater than 100,000 CFU/mL. The susceptibility was to follow. This report was not noted as reviewed.</p> <p>A 7/13/25 at 12:13 pm final UC result lab report indicated the urine sample was collected on 7/9/25 at 1:07 a.m. and received on 7/10/25 at 7:39 a.m. The result indicated growth of more than 100,000 Enterobacter cloacae complex, and to see the previous culture for susceptibility report. The physician responded to this result on Monday, 7/14/25, and ordered to stop cefuroxime and to start Nitrofurantoin 100 mg (antibiotic) twice a day for five days. This order was noted as reviewed on Tuesday, 7/15/25, by an unidentified staff member.</p> <p>A 7/13/25 at 12:13 p.m., a final UC result with susceptibility lab report indicated the sample was collected on 7/10/25 at 1:30 p.m. and received on</p>	F0684		

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F0684 SS = G	<p>Continued from page 34 7/10/25 at 2:53 p.m. It indicated the Enterobacter cloacae complex bacteria was not susceptible to cefuroxime, but it was susceptible to Nitrofurantoin. This report was noted as reviewed by two unidentified staff members on an unknown date.</p> <p>On 7/15/25 at 10:45 a.m., a progress note by LPN H indicated that the physician originally ordered cefuroxime 500 milligrams (mg) twice a day for five days, but after the UC results, he discontinued that antibiotic order and ordered Nitrofurantoin 100 mg twice a day for five days.</p> <p>On 7/15/25 at 11:36 a.m., a progress note by LPN H indicated that the resident had severe flank pain and Nitrofurantoin antibiotic was to be started that day at 5:00 p.m. Resident 112's son was in the resident's room and was updated on the lab results and treatment plan. Since resident 112's pain was not controlled he wanted her sent to the emergency room.</p> <p>On 7/15/25 at 11:40 a.m., a progress note by director of nursing (DON) B indicated that she completed an investigation on why the 7/11/25 physician's order for cefuroxime was not started. It was found at the same time as the 7/15/25 order was found to stop the cefuroxime and to start nitrofurantoin. She updated the resident's family and physician regarding the incident.</p> <p>On 7/15/25 at 3:45 p.m., a progress note by social service designee (SSD) E indicated that resident 112's son discussed his concerns about the situation about his mother with her, and told SSD E that the resident had an infection in her spine. SSD E offered to him to hold the resident's bed at the facility for when she discharged from the hospital, but he declined.</p> <p>On 7/15/25 at 5:34 p.m., a progress note by LPN LL indicated that resident 112 was admitted to the hospital related to a UTI.</p> <p>4. Interview on 3/26/26 at 1:04 p.m. with LPN O revealed that physician orders were to be processed within the first few hours after being received and completed by the end of their shift.</p> <p>Physician orders were faxed by the physician's office</p>	F0684		

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F0684 SS = G	<p>Continued from page 35 to the facility's fax machine, which was specific to the unit where the resident resided. Sometimes the faxes were received at the front reception area fax machine, and the managers would check that fax machine. Sometimes they did not receive those orders until the next morning, and they processed them as soon as they could.</p> <p>5. Interview on 3/26/26 at 1:20 p.m. with LPN W revealed the facility received physician orders by fax or by paper if the physician was at the facility. Faxed orders were supposed to go to the unit where the resident resided, and sometimes the orders went to the front reception area fax machine, which was to be checked by the managers, including on weekends.</p> <p>During non-business hours, on-call physicians were available if a resident needed physician services. The nursing staff could contact them if a resident had a change in their medical condition.</p> <p>If abnormal lab results were received during non-business hours, and a resident's current ordered antibiotic was not susceptible to treat the resident's infection, the nursing staff were to notify the on-call provider.</p> <p>If UA was ordered, they had 24 hours to collect it, put it in the refrigerator after it was collected, and it would be taken to the lab in the morning.</p> <p>To process physician orders, two nurses needed to note them as reviewed to ensure they were completed correctly. She was unsure how quickly the orders needed to be processed after being received, but they needed to be completed by the end of their shift.</p> <p>6. Interview on 3/30/26 at 2:05 p.m., 4:00 p.m., and 4:35 p.m. with DON B revealed she was unsure why resident 112's 7/9/25 UA was recollected. If physician orders were received for a UA, it needed to be collected that same day. If the sample was not collected that same day, the physician needed to be notified.</p> <p>She expected that physician orders would be processed the same day they were received. She expected physician</p>	F0684		

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F0684 SS = G	<p>Continued from page 36 orders to be noted as reviewed and to include the date, not the time, and by whom.</p> <p>She expected the resident's physician to be notified of lab results. If the physician was out of the office or if it was after hours, she expected the nurse to notify the on-call physician.</p> <p>After the incident regarding 112, she stated that only nurse managers and unit managers received education regarding checking the fax machine at the front reception area for physician orders. Her investigation did not include information regarding resident 112's UA not being collected promptly, or that the on-call physician was not notified of the preliminary lab results. The incident investigation did not include steps to determine if other residents were affected. She did not educate nurses to check the main fax machine for orders throughout their shift, as indicated on the provider's report sent to the SD DOH.</p> <p>7. Interview on 3/30/26 at 3:52 p.m. with SSD E revealed she did not remember what the frustrations resident 112's son talked to her about on 7/15/25 at 3:45 p.m. She documented in the EMR if residents or their families reported concerns to her.</p> <p>8. Interview on 3/31/26 at 1:20 p.m. with administrator A revealed she did not recall if she spoke with resident 112's son. If she had, she would have documented it in the EMR.</p> <p>9. Interview on 3/24/26 at 3:24 p.m. with resident 88 revealed that after he received dialysis treatments, he was dizzy and felt better the next day. When asked if staff were aware of his dizziness, he stated he was not sure.</p> <p>10. Review of resident 88's EMR revealed he admitted to the facility on 10/3/25. His 2/17/26 BIMS assessment score was 15, which indicated his cognition was intact.</p> <p>He had diagnoses of end-stage renal disease (the kidneys no longer work well enough to sustain life), dependence on renal dialysis, hypotension (low blood pressure), hypertension (high blood pressure), and heart failure (where the heart becomes too weak or</p>	F0684		

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F0684 SS = G	<p>Continued from page 37 stiff to pump blood efficiently).</p> <p>He had 2/2/26 physician's orders for dialysis treatments on Monday, Wednesday, and Friday, and the order commented that his ride came at 5:00 a.m.</p> <p>A 2/25/26 progress note indicated he had his dialysis fistula (a surgical connection between an artery and a vein on the arm created to make an access point for cleaning the blood) placed.</p> <p>He had 2/2/26 physician's orders to receive Midodrine 10 mg three times a day for hypotension, and it was to be held if his systolic blood pressure (SBP) (top number of the blood pressure) was 120 or greater.</p> <p>He had 2/3/26 physician's orders to receive Metoprolol Succinate ER (extended release) 25 mg daily for hypertension. This medication order did not have parameters when it needed to be held.</p> <p>Resident 88's March 2026 medication administration record (MAR) indicated he did not receive Midodrine on Monday, Wednesday, and Friday mornings, the days of his dialysis treatments. From 3/9/26 through 3/30/26, he received Metoprolol Succinate ER one time, on 3/20/26, on the day of his dialysis treatments. There was no documentation that his physician was notified that he did not receive those medications consistently as ordered on those days.</p> <p>Resident 88's dialysis records from 3/9/26 through 3/25/26 indicated that his blood pressure before dialysis was 112/62 on 3/9/26, his 3/11/26 records were not provided, his blood pressure on 3/13/26 was 122/24, on 3/16/26 it was 118/62, on 3/18/26 it was 115/62, on 3/20/26 it was 98/56, on 3/23/26 it was 117/62, and on 3/25/26 it was 118/62.</p> <p>Resident 88" March 2026 MAR indicated that his blood pressure was 79/44 on 3/20/26 before his 5:30 p.m. scheduled dose of Midodrine was given. His blood pressure was not checked again until the next morning, 3/21/26 at 7:30 a.m., was 81/43. There was no documentation that his provider was notified of those low blood pressures. He received his metoprolol (a medication that can lower blood pressure) on these</p>	F0684		

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F0684 SS = G	<p>Continued from page 38 days.</p> <p>Resident 88's treatment record (TAR) indicated that staff were to monitor him for post-dialysis complications, including low blood pressure symptoms, twice daily on Mondays, Wednesdays, and Fridays. His treatment record indicated the only day he had symptoms was on 3/6/26, and the other days he did not.</p> <p>11. Interview on 3/26/26 at 1:04 p.m. with LPN O revealed that the physician was to be notified when a resident vital sign (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) were not within the specific parameters, included in the resident's physician's orders.</p> <p>12. Interview on 3/31/26 with DON B at 1:05 p.m. and 2:15 p.m. revealed she expected resident 88 to be given Midodrine before he went to dialysis if his blood pressure was within his ordered parameters. She verified that his physician was not notified that it was not given consistently before dialysis when his blood pressure was outside those parameters.</p> <p>If his blood pressure was low and he was not symptomatic, she did not expect his blood pressure to be rechecked or his physician to be notified. The physician would be notified based on the nurse's assessment. She stated there was no "hard and fast rule" when the physician needed to be notified. The facility did not have a policy regarding vital sign parameters. The parameters to notify the physician were not in the resident 88's orders.</p> <p>13. Review of the provider's 11/18/25 Following Physician Orders policy revealed that "all physician orders should be followed as ordered". If orders are not followed, the physician is to be made aware, including "omission, medication not in stock, repeated resident refusals for medications/treatments, etc."</p> <p>14. Review of the provider's 11/18/25 Notification of Change of Condition policy revealed that the facility will notify the physician of a resident's change in status.</p>	F0684		

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F0684 SS = G	Continued from page 39 The facility must promptly notify the physician when there is a significant change in the resident's physical status. The physician was to be notified if a resident refused treatments or procedures at least three consecutive times.	F0684		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, SD DOH complaint intake report, record review, observation, interview, and policy review, the provider failed to implement pressure ulcer (skin and/or underlying tissue injury due to prolonged pressure) prevention interventions for one of one sampled resident (16) identified with risk for developing pressure ulcers who developed a stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer on her left buttock and one of one sampled resident (9) with a history of pressure ulcer and identified with risk for developing pressure ulcer who developed a stage III (3; open wound with full thickness skin loss, fatty tissue may be visible) pressure ulcer to his right gluteal fold (the horizontal skin crease separating the buttock from the posterior upper thigh) and his coccyx (tailbone), a left lateral heel deep tissue injury (DTI), left lateral lower leg stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer to his left lateral (outer) lower leg. Findings include:	F0686	1. Resident #2's skin assessed on 04/08/26 with new skin impairment identified and treatment in place. Resident #16's skin was assessed on 04/06/26 with no new skin impairment areas identified. Residents #3 and #9 discharged. 2. All residents are at risk for deficient practice. All residents identified with having a high-risk for skin impairment were reassessed and their care plans were reviewed and updated as needed to ensure pressure ulcer prevention interventions are in place. 3. Root Cause Analysis: Nursing staff failed to ensure consistent implementation and monitoring of pressure ulcer prevention interventions for high risk residents. All staff lacked knowledge of role in pressure ulcer prevention. The administrator, DON, and interdisciplinary team, in collaboration with the medical director, will review, revise, and/or create policies and procedures that address assessing residents for the risk of developing pressure ulcers, identifying and implementing individualized pressure ulcer prevention interventions, including but not limited to repositioning and pressure-reduction strategies such as air mattresses, and following and providing established standards of care for pressure ulcer prevention and management of facility-acquired pressure ulcers. Education and training will be provided for all staff about their roles, responsibilities, and assigned tasks regarding pressure ulcer prevention and management. Competencies of staff knowledge and implementation of all aspects of the education provided will be conducted by 05/08/2026. Those not in attendance at education sessions will be educated prior to their next shift worked.	05/08/2026

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F0686 SS = G	<p>Continued from page 40</p> <p>1. Review of the provider's 3/17/26 FRI submitted to the SD DOH regarding resident 16 revealed:</p> <p>*Resident 16's daughter reported concerns related to the quality of care being provided for resident 16 related to her not being provided with routine bathing, not being "changed" regularly and not consistently being assisted out of bed for meals.</p> <p>*After receiving resident 16's daughter's concerns the provider completed a skin assessment and found resident 16 had a two centimeter (cm) in length by 0.6 cm in width stage II pressure ulcer to her left buttock and "Scabs that appear to be from being in bed".</p> <p>-The location of the scabs was not identified on the 3/17/26 FRI.</p> <p>*The provider's standing orders for skin concerns were initiated on 3/17/26.</p> <p>*The provider initiated a nursing order for resident 16 to be assisted into her "chair" for lunch and supper meals per the daughter's request and the management staff was to be notified if resident 16 refused to get up into her chair.</p> <p>2. Review of resident 16's electronic medical record (EMR) revealed:</p> <p>*She admitted to the facility on 3/2/26.</p> <p>*Her 3/6/26 Brief Interview of Mental Status (BIMS) assessment score was 4, which indicated her cognition was severely impaired.</p> <p>*Her diagnoses included diabetes (a condition involving disruptions in how the body regulates blood sugar), depression, and senile degeneration of the brain (progressive loss of cognitive function and brain tissue associated with aging).</p> <p>*Her 3/2/26 Braden Scale (a tool used to assess the risk of developing pressure ulcers) assessment indicated she had a high risk for the development of a pressure ulcer.</p> <p>*Her 3/3/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated resident 16 had difficulty with communication, required the assistance of one staff member for repositioning in bed, required a</p>	F0686	4. DON or designee will complete audits on 5 random residents to ensure pressure ulcer prevention interventions are identified and in place weekly x6 weeks then monthly x2 months. DON or Designee will present audit findings monthly in QAPI meeting for further progress review and recommendations.	

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F0686 SS = G	<p>Continued from page 41 sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position)with the assistance of one staff member for transfers, and was dependent upon staff for her personal hygiene needs.</p> <p>*She had a 3/3/26 focus area on her care plan for the potential for "impairment to skin integrity [related to] weakness [and] decreased mobility with intervention of "Apply wound treatment as ordered by the physician", "Assess for pain and administer pain medication as ordered, observe feedback and notify MD [medical doctor] as necessary", "Encourage good nutrition and hydration in order to promote healthier skin".</p> <p>*A 3/11/26 skin assessment indicated resident 16 had blanchable redness (reddened skin turned white when pressure was applied to that area) to her buttocks and barrier cream (a cream to provide a moisture barrier) to the skin on her buttocks.</p> <p>*On 3/16/26 licensed practical nurse (LPN) X documented a facility acquired 2 centimeter (cm) in length by 0.6 cm in width abrasion to resident 16's left buttocks and coccyx (tailbone) with redness surrounding the area, a facility acquired 4 cm in length by 0.3 cm in width undescribed area to the back of resident 16's right thigh, and a facility acquired 1.5 cm in length by 0.2 cm in width undescribed area to the back of resident 16's left thigh.</p> <p>*On 3/17/26 LPN Y documented resident 16's pressure ulcer on her left buttock as a stage II that measured 3.5 cm in length by 0.8 cm in width by 0.1 cm in depth with redness surrounding the pressure ulcer.</p> <p>*On 3/17/26 the focus area related to skin integrity was revised to indicate that, resident 16 "has actual impairment to skin integrity. Left Buttock Pressure, Stage 2. Bilateral [both sides] Posterior [towards the backside] Upper thighs, Scabs" with added interventions of Consult RD [registered dietician] as needed for nutritional recommendations for optimal wound healing", "Monitor/document location, size, and treatment of skin ulcer. Report abnormalities, failure to heal, signs and symptoms of infection, maceration [moisture related skin damage] etc. to MD" and "Weekly monitoring of wounds by wound nurse or designee: Assessments, recommendations, measurements."</p> <p>*On 3/23/26 LPN Y documented resident 16's pressure ulcer on her left buttocks as a stage II that measured 3 cm in length by 2 cm in width by 0.1cm in depth.</p> <p>-That pressure ulcer was larger in area than the</p>	F0686		

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F0686 SS = G	<p>Continued from page 42 assessment on 3/17/26.</p> <p>*On 3/23/26 the skin integrity focus area had added interventions of, "Encourage/Assist to turn and reposition at least every 2 hours and as needed", "Keep skin clean and dry. Use lotion on dry skin", "Pressure redistributing cushion to wheelchair", and "Pressure redistributing mattress to bed".</p> <p>3. Observation and interview on 3/25/26 at 2:15 p.m. of wound care certified/regional nurse consultant (RNC) L and licensed practical nurse (LPN) X changing the wound dressing on resident 16's left buttock pressure ulcer revealed:</p> <p>*Resident 16 was lying on her back in bed. The head of resident 16's bed was elevated, and resident 16 had slid down in bed and was bending at her chest.</p> <p>*LPN X and wound nurse certified/RNC L lowered the head of the bed, rolled resident 16 from side to side to cleanse her pressure ulcer, applied a new dressing on the wound, and replaced her incontinence brief.</p> <p>*LPN X and wound nurse certified/RNC L then rolled resident 16 onto her back again and raised the head of resident 16's bed.</p> <p>4. Interview on 3/25/26 at 2:50 p.m. with certified nursing assistant (CNA)/ certified medication aid (CMA) R revealed:</p> <p>*Director of nursing (DON) B and administrator A told her resident 16's daughter was concerned when she came to visit her mother, that she was still in her bed with her night gown on, CNA/CMA R had transferred resident 16 by pivot-transfer (when assisted to a standing position, the resident then turns their body to move to another surface) instead of the care planned sit-to-stand, and she had developed sores on her bottom.</p> <p>*CNA/CMA R stated she was assigned to care for resident 16 that day and that was the first time she had cared for resident 16.</p> <p>*She looked in resident 16's room and asked if she needed anything several times that day, but the resident did not reply to her, so she left her in bed.</p> <p>5. Interview on 3/26/26 at 10:15 a.m. with CNA/CMA V</p>	F0686		

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F0686 SS = G	<p>Continued from page 43 revealed:</p> <p>*She was responsible for providing resident 16's cares on 3/26/26.</p> <p>*She used the Kardex (a report of the resident's care needs and interventions) or the pocket care plan (a document that identifies residents' care needs and interventions) to determine each resident's care needs.</p> <p>*She did not know what pressure prevention interventions were used before resident 16 developed her pressure ulcer or what was currently being provided for pressure reduction.</p> <p>6. Observation on 3/30/26 at 1:52 p.m. of resident 16 in her room revealed:</p> <p>*She was lying in bed on her back.</p> <p>*The head of her bed was elevated and she was in a position that she bent at her chest.</p> <p>7. Phone interview on 3/30/36 at 2:08 p.m. with resident 16's daughter revealed:</p> <p>*She spoke with the facility's administration about concerns she had related to the quality of care her mother had received.</p> <p>*She had come in to visit her mother one day around 2:30 p.m. (near the date she reported her concerns) and she found her mother lying in bed with her pajamas on and food on her face and clothing.</p> <p>*Her mother had been bathed one time between her admission date (3/2/26) and 3/16/26.</p> <p>*She was told by the wound nurse that her mother had developed a pressure ulcer on her buttocks.</p> <p>*The wound nurse said the pressure ulcer was because the staff were pulling her mother up in bed by her arms instead of using a lift sheet.</p> <p>*Resident 16's daughter stated she had turned on her mother's call light one day, because she needed to be boosted up in bed. No one answered the call light for 30 minutes, so she went out into the hallway and could not locate a staff member. She went into another hallway and found a staff member to assist her mother.</p>	F0686		

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F0686 SS = G	<p>Continued from page 44</p> <p>*She stated resident 16 was not able to use her call light to get assistance with her needs and could not get out of bed or reposition herself in bed without the staff's assistance.</p> <p>8. Observation on 3/30/26 at 3:30 p.m. of resident 16 in her room revealed:</p> <p>*She was lying on her back.</p> <p>*The head of her bed was elevated, and she was bending at her chest.</p> <p>9. Interview on 3/31/26 at 8:56 a.m. with restorative aide (RA) PP revealed she:</p> <p>*Used the Kardex to determine each resident's care needs.</p> <p>*Did not know what pressure prevention measures had been in place for resident 16 before she developed the pressure ulcer on her left buttocks or what was currently being used for pressure reduction interventions.</p> <p>*Acknowledged that residents who were not repositioned were at increased risk for the development of a pressure ulcer.</p> <p>*Acknowledged that residents who did not receive routine bathing were at risk for the development of skin impairments.</p> <p>10. Interview on 3/31/26 at 10:02 a.m. with LPN Y, wound care certified, RNC L, and DON B revealed:</p> <p>*LPN Y started her role as the provider's wound nurse in the beginning of March 2026.</p> <p>*She was supervised by DON B and wound care certified, RNC L.</p> <p>*She had received wound education from online resources, wound care certified RNC L, and a consultant from their wound dressing supply company.</p> <p>*LPN Y stated the nurse who was caring for resident 16 identified the pressure ulcer on resident 16's buttock and reported that ulcer to LPN Y.</p> <p>*LPN Y assessed the newly identified pressure ulcer on</p>	F0686		

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F0686 SS = G	<p>Continued from page 45 resident 16's left buttock the day after it was found.</p> <p>*LPN Y stated the scabs on resident 16's upper back of her thighs were identified on the same day she assessed resident 16's left buttock pressure ulcer.</p> <p>*She stated the scabbed areas on the upper back of resident 16's thighs were determined as being caused by shearing (a mechanical force occurring when skin sticks to a surface such as sheets while the underlying tissue and bone slide causing tissue layers to tear, stretch and damage blood vessels).</p> <p>*LPN Y stated she notified resident 16's daughter and physician of the newly identified pressure ulcer and added resident 16 to her wound rounds for the assessment and documentation of the wound weekly.</p> <p>*Certified wound nurse/RNC L acknowledged that resident 16's head of her bed being elevated increased the risk of shearing and the development of a pressure ulcer when she slid down in her bed.</p> <p>*DON B verified resident 16 could not turn herself in bed without staff assistance was able to adjust her hips by herself. She was unable to raise her hips up off the bed to reposition herself to prevent shearing of her skin.</p> <p>*DON B expected the staff to assist resident 16 with turning while she was in bed</p> <p>*Upon admission to the facility each resident's skin was to be assessed for alterations in their skin, and a Braden scale assessment was completed to assess for that resident's risk for developing a pressure ulcer.</p> <p>*Resident 16 did not have alterations in her skin upon her admission to the facility on 3/2/26, but she was identified as being at risk for the development of a pressure ulcer.</p> <p>11. Interview on 3/31/26 at 10:45 a.m. with DON B revealed:</p> <p>*All residents were placed on a pressure reduction mattress upon admission and received a dietary consultation. Barrier cream was to be applied with each incontinence product change or if the resident was assisted to the toilet, if that resident had episodes of incontinence.</p> <p>*DON B was unable to find documentation in resident</p>	F0686		

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F0686 SS = G	<p>Continued from page 46 16's EMR to support barrier cream was applied to the resident's skin or that she had refused the application of barrier cream.</p> <p>*DON B expected residents who could not reposition themselves to be assisted with repositioning by the staff every two hours, according to "standard practice".</p> <p>*That repositioning was not documented by the staff when it was completed. If a resident refused repositioning DON B expected the nurse to be notified of the refusal so it could be documented in that resident's EMR.</p> <p>*DON B could not find documentation that supported that resident 16 refused repositioning in her EMR.</p> <p>*She expected the nurse managers to round (monitor) in their hallways to be sure each resident's care needs were attended to, which included repositioning.</p> <p>*Air mattresses were generally not used for pressure ulcer prevention, but were typically used if a resident had a stage III pressure ulcer and on a case-by-case basis when a resident was receiving hospice services.</p> <p>*DON B verified resident 16 did not have an air mattress prior to or after the development of her pressure ulcer.</p> <p>*The pressure ulcer preventions put into place before resident 16 developed a pressure ulcer were standard for all admissions and not individualized related to her identified risk for being at risk for the development of a pressure ulcer.</p> <p>*She expected the staff to document in the resident's EMR if they refused any cares that were offered to them such as assisting a resident out of bed, bathing, repositioning, or skin cares.</p> <p>12. Interview on 3/31/26 at 1:41 p.m. with administrator A revealed:</p> <p>*She had received concerns from resident 16's daughter on 3/17/26 related to care that resident 16 was receiving.</p> <p>*After she received those concerns LPN Y assessed resident 16's skin and identified the pressure ulcer on resident 16's buttock.</p>	F0686		

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F0686 SS = G	<p>Continued from page 47</p> <p>*She thought resident 16's scabbed areas were caused by CNA/CMA R having used a split leg sling (a piece of the sling goes behind each leg and crosses over through the legs of the resident to attach to the lift) for the full body lift, so they changed resident 16 to be transferred with a full body sling (a one pieced complete rectangular sling).</p> <p>-Resident 16 was care planned to be a sit-to-stand lift at the time she developed the pressure ulcer on her left buttocks and the scabbed areas on the upper back of her thighs were found.</p> <p>*Administrator A stated resident 16 was receiving hospice services and refused care at times so she expected the resident to develop some skin breakdown.</p> <p>*She expected the staff to follow the residents' care plan while attending to each resident's care needs.</p> <p>13. Review of the SD DOH complaint intake report for resident 9 revealed:</p> <p>*He was seen in an emergency department on 3/23/26 and was dehydrated despite being provided nutrition products and water through a feeding tube (a tube surgically placed through the abdomen into the stomach to administer liquid nutrition, fluids and medications).</p> <p>*He returned to facility on 3/23/26.</p> <p>*He discharged to an inpatient hospice facility on 3/25/26.</p> <p>*Upon admission to the hospice care facility he presented with the following wounds gluteal cleft wound, left buttocks wound, right upper thigh posterior wound, left heel wound left lateral calf, right lateral calf, right upper thigh anterior, penile wound, mouth and tongue red and irritated with skin peeling off, which made speech difficult for him.</p> <p>14. Review of resident 9's electronic medical record (EMR) revealed:</p> <p>*He admitted to the facility on 1/9/26.</p> <p>*He admitted to hospice services on 3/21/26.</p> <p>*He was discharged to an inpatient hospice facility on 3/25/26.</p>	F0686		

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F0686 SS = G	<p>Continued from page 48</p> <p>*He had diagnoses of Spinal stenosis (narrowing of spaces within the spine which puts pressure on nerves and spine), Chronic kidney disease (a long-term condition where kidneys are damaged and cannot filter blood properly), Atherosclerotic heart disease (a chronic condition where fats, cholesterol and plaque build-up in artery walls restricting blood flow to the heart), Urine retention (inability to fully empty the bladder), Dysphasia (difficulty swallowing), Protein-calorie malnutrition (a severe deficiency of protein and calories, causing muscle wasting, weight loss and fatigue).</p> <p>*His 3/25/26 Brief Interview for Mental Status (BIMS) assessment score was 13 which indicated his cognition was intact.</p> <p>*His 3/19/26 Braden scale (assessment for predicting injury risk) score indicated he had a high risk for developing pressure ulcers.</p> <p>*He had skin evaluations completed on 1/16/26 which indicated he had redness on his bilateral heels and a PEG tube (a medical device inserted through the abdominal wall into the stomach to deliver nutrition, fluids, and medications directly, bypassing the mouth and esophagus) site.</p> <p>*He had a skin evaluation completed on 1/23/26 which indicated he had an abdomen-PEG tube site, and treatments in place to his right heel blister, upper thigh blister, mid back surgical site, coccyx pressure ulcer.</p> <p>*He had a 1/30/26 skin evaluation that identified a right heel blister, pressure ulcer to sacrum, left gluteal fold pressure ulcer, left lower back pressure ulcer, and right upper thigh gluteal fold pressure ulcer.</p> <p>*His 2/7/26 skin evaluation indicated that resident 9 was not available for a skin assessment due to his hospitalization.</p> <p>*He had a 2/14/26 skin evaluation that indicated no skin concerns and his feeding tube was intact with no concerns.</p> <p>*He had a 2/22/26 skin evaluation indicated that he was not available for a skin assessment due to his hospitalization.</p> <p>*His 3/2/26 skin evaluation identified redness to the</p>	F0686		

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F0686 SS = G	<p>Continued from page 49 coccyx, that treatment was in place for wound prevention and he had a feeding tube to his left abdomen with no signs or symptoms of infection.</p> <p>*His 3/9/26 skin evaluation identified that treatment was in place for wound prevention to his coccyx and he had a feeding tube to his left abdomen with no signs or symptoms of infection.</p> <p>*His 3/10/26 Skin alteration evaluation identified a right gluteal fold pressure ulcer measuring 2.5 centimeters (cm) x 2 cm x 0.1 cm stage II.</p> <p>*His 3/16/26 skin evaluation identified a coccyx wound treatment was in place for wound prevention, and he had a feeding tube to his left abdomen with no signs or symptoms of infection noted.</p> <p>*A 2/12/26 skin/wound progress note regarding wound rounds were completed for pressure ulcerations to resident 9's coccyx, left gluteal fold, left lower back, and right outer heel, right upper thigh at gluteal fold, a mid-back surgical wound. Those areas were healed, and the provider and resident were updated.</p> <p>*On 3/10/26 a skin/wound progress note indicated an open area under resident 9's right buttock that measured 2 cm x 2.5 cm x 0.1cm that was freely bleeding. The resident complained of pain with cleaning of the area, and collagen and border gauze were applied. The provider and family were notified.</p> <p>*On 3/13/26 a skin/wound progress note indicated that his right gluteal fold was reclassified from moisture associated skin damage (MASD) to a pressure ulcer after reassessment. His physician was notified.</p> <p>*On 3/14/26 a physician's order for "Wound right gluteal fold cleanse apply collagen cover with border gauze, every day shift for pressure" was received and entered into his treatment administration record (TAR).</p> <p>*On 3/19/26, a skin /wound progress note indicated a pressure area to his coccyx, measuring 9 cm x 6.5 cm x 0.20 cm and that an air mattress would be placed in the resident's room to assist with pressure offloading.</p> <p>*On 3/19/26 a skin/wound progress note stated "pressure area to left lateral heel with non-blanchable (area does not turn white when pressed with a finger) discoloration consistent with a deep tissue injury (DTI), measurements 6.6 cm x 5.4 cm depth not measurable due to intact skin. PCP notified, added to</p>	F0686		

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F0686 SS = G	<p>Continued from page 50 weekly rounds, heel boots were applied, and air mattress will be placed in the resident room to assist with pressure offloading".</p> <p>*On 3/19/26 a skin/wound progress note stated "pressure noted to left lateral lower leg with blister present consistent with stage 2 pressure injury measurements 13 cm x 3.5 cm depth unable to be measured due to intact skin provider notified, placed on weekly rounds and air mattress added to resident room to assist with pressure offloading".</p> <p>*On 3/19/26 a skin/wound progress note stated "right gluteal fold pressure injury measured 6 cm x 5.5 cm x .10 cm and Urethral meatus surgical incision [measure] 1.2 cm x 0.9 cm, Right heel redness noted but blanchable (indicates blood flow is present to the area). Care plan had been reviewed and updated".</p> <p>*He had physician's orders on 3/19/26 for:</p> <p>-Wound care urethral meatus cleanse with wound cleanser, pat dry and apply bacitracin (antibiotic ointment) every day and night shift.</p> <p>-Wound care left lateral lower leg pressure/blister cleanse with normal saline, pat dry, cover with no sting skin prep to intact skin, apply border foam dressing every day shift every other day.</p> <p>-Wound care coccyx pressure cleanse with normal saline, pat dry, cover with no sting skin prep to intact skin (peri wound) and cover with bordered foam dressing every day shift every other day.</p> <p>*He had a physician's order on 3/24/26 for staff to encourage resident 9 to wear heel boots (specialized footwear designed to eliminate pressure on the heel and foot to prevent pressure injury) when in bed or float heels (elevating heels off mattress to prevent pressure ulcers) every shift.</p> <p>*His March 2026 treatment administration record (TAR) revealed the above ordered wound care treatments were documented completed on 3/20/26 and 3/22/26. They were not documented as completed on 3/24/26.</p> <p>*His current care plan indicated:</p> <p>-He had actual impairment to skin integrity of right gluteal fold stage III pressure injury, Urethral meatus surgical incision, left lateral heel pressure DTI, left lateral lower leg pressure blister stage II, coccyx pressure ulceration stage III, blanchable redness to</p>	F0686		

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F0686 SS = G	<p>Continued from page 51 groin, coccyx and sacrum initiated on 1/9/26 and revised on 3/19/26.</p> <p>-He had a history of scattered scabs and bruising to bilateral upper arms, right inner thigh, red raised rash, right inner heel blanchable redness, closed left gluteal fold, pressure stage II, closed left lower back pressure stage II, closed right outer heel pressure stage II, right upper thigh at gluteal fold pressure stage III and a history of mid back surgical incision initiated on 1/9/26 and revised on 3/19/26.</p> <p>-He had interventions:</p> <p>--An air mattress to his bed, that was initiated on 3/19/26.</p> <p>--Apply a pressure redistributing cushion to the wheelchair, initiated on 1/20/26 and revised on 1/30/26.</p> <p>--Apply wound treatment as ordered by physician initiated on 1/9/26.</p> <p>--Assess for pain and administer pain medication as ordered, observe for feedback and notify MD as necessary initiated on 1/9/26.</p> <p>--Consult RD [registered dietitian] as needed for nutritional recommendations for optimal wound healing initiated on 1/9/26.</p> <p>--Encourage good nutrition and hydration to promote healthier skin initiated on 1/9/26.</p> <p>--Keep skin clean and dry. Use lotion on dry skin initiated on 1/9/26.</p> <p>--Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, macerations, etc. to MD initiated on 1/9/26 and revised on 3/19/26.</p> <p>--Weekly monitoring of wounds by wound nurse or designee assessments, recommendations, and measurements initiated on 1/20/26 and revised on 3/19/26.</p> <p>--He required assistance with ADL's (bed mobility, transfers, dressing, locomotion, personal hygiene, eating and toileting) initiated on 1/9/26 and revised on 2/1/26.</p> <p>--He had interventions of two-person staff assistance with mechanical full body lift for transfers, he was</p>	F0686		

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F0686 SS = G	<p>Continued from page 52 dependent for bed mobility, dressing, personal hygiene, toileting, and bathing initiated on 1/9/26 and revised on 1/9/26.</p> <p>--He would use two mobility bars as an assistive device to help him to turn, reposition and/or transfer, initiated on 3/4/26 and revised on 3/4/26.</p> <p>15. Interview on 3/31/26 with Physician Assistant Certified (PA-C) QQ revealed:</p> <p>*Resident 9 had developed sores in his mouth the evening of 3/24/26. She was notified by the hospice staff who requested an order for Lidocaine (a prescription anesthetic used to temporarily relieve pain) solution which she ordered on 3/25/26 when she saw him.</p> <p>*Resident 9 often refused cares. She was notified by the facility that he had refused to get up in his wheelchair twice daily, to be weighted and was refusing to participate in physical therapy.</p> <p>*She felt he was bedfast (confined to bed) and he refused to wear the heel lift boots on his heels.</p> <p>*She would expect the facility to have preventative measures in place to prevent re-occurrence of developing pressure ulcers such as an air mattress.</p> <p>16. Interview on 3/31/26 at 8:49 a.m. with registered nurse (RN) unit manager J revealed:</p> <p>*Resident 9's air mattress was ordered on 3/19/26.</p> <p>*He refused to get up twice a day and they notified the MD of those refusals around 2/13/26.</p> <p>*The facility-initiated bed mobility bars to aid with repositioning on his bed.</p> <p>*She was unsure if he was on a turning or positioning schedule.</p> <p>*He had heel lift boots that he refused to wear.</p> <p>*She felt the facility did the best they could with residents to prevent them from redeveloping pressure ulcers.</p> <p>17. Interview on 3/31/26 at 10:25 a.m. with licensed</p>	F0686		

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F0686 SS = G	<p>Continued from page 53 practical nurse (LPN) Y and director of nursing (DON) B revealed:</p> <p>*Staff encouraged resident 9 daily to get up in his wheelchair twice daily. On admission he had a pressure reducing mattress on his bed, InterDry (a cloth that wicks moisture away from skin) in his abdominal folds, and Triad wound dressing paste to his coccyx.</p> <p>*On 3/19/26 his pressure injuries were documented, an air mattress was ordered, new treatment orders were received, his provider was notified of the pressure ulcers and weekly skin evaluations were started.</p> <p>*The floor nurses complete the weekly skin evaluations.</p> <p>*He received orders for heel lift boots for his heels. He would allow them to be placed and then would ask the certified nursing assistants (CNA's) to remove them shortly after applying them.</p> <p>*The facility's standard practice was to reposition all residents every two hours.</p> <p>*His doctor or provider was notified of his refusals to wear his heel lift boots and to get up into his wheelchair.</p> <p>*He had a pressure redistributing mattress; and air mattresses were usually implemented after a resident had a stage III pressure ulcer.</p> <p>*He had orders to be up in his wheelchair twice daily (BID), which he refused to do.</p> <p>*He had wound care orders for his pressure ulcers.</p> <p>*He could move in his bed but required assistance from staff for that.</p> <p>*He was not on a repositioning schedule.</p> <p>*His heels were offloaded and repositioned as needed.</p> <p>*The pressure ulcer that resident 9 had on admission had healed on 2/11/26 and then redeveloped.</p> <p>18. Interview on 3/31/26 at 10:45 a.m. with DON B revealed:</p> <p>*She expected wound orders to be completed by the nursing staff as ordered.</p>	F0686		

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F0686 SS = G	<p>Continued from page 54</p> <p>*She agreed that if wound orders had not been signed as completed in the TAR on 3/24/26 they were not completed.</p> <p>*She stated that his wound areas would become worse if his treatments were not completed.</p> <p>*She felt that pressure redistribution mattresses were effective pressure ulcer prevention interventions.</p> <p>*Resident 9 admitted to hospice services on 3/21/26.</p> <p>*She was unsure if an air mattress would have prevented his re-occurrence of his 3/19/26 developed pressure ulcers.</p> <p>*She expected all refusals to be documented or the CNAs to tell the nurse what approaches were successful, so they could be documented.</p> <p>19. Review of the provider's revised March 23, 2023 Skin and Pressure Injury Prevention Program policy revealed:</p> <p>**"To ensure a resident who enters the facility without pressure injuries does not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable. To provide care and services to prevent pressure injury development and to promote the healing of pressure injuries/wounds that are present."</p> <p>**3. Risk Factor- Bed-fast Resident:</p> <p>-a. Offer repositioning at least every two hours and more frequently as needed if resident unable to move self.</p> <p>-b. Consider off-loading pressure hourly if the head of the bed is greater than 30 degrees (i.e., for residents with tube feeding or respiratory issues).</p> <p>-c. Use a special mattress that contains foam, air, gel, or water, as indicated.</p> <p>-d. Raise the head of the bed as little and for as short a time as possible, and only as necessary for meals, treatments, medical necessity, and resident comfort. e. Unless resident has both sacral and ischial pressure ulcers, avoid placing directly on the greater trochanter for more than momentary placement."</p>	F0686		
F0688 SS = E	Increase/Prevent Decrease in ROM/Mobility	F0688		

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F0688 SS = E	Continued from page 55 CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure an ongoing restorative nursing program was completed according to the residents' care planned needs for two of two sampled residents (40 and 43) at risk for a decline in range of motion. Findings include: 1. Observation and interview on 3/25/26 at 9:10 a.m. with resident 40 in her room revealed that she was frustrated that the fingers on her right hand were stiff and she could not make a fist. She felt she was not receiving the exercises she needed to maintain her strength and was getting weaker. She stated that there used to be exercises, but no one came to get her for her exercises anymore. She stated that she complained to the therapy department about not getting her exercises and was told those exercises were to be completed by the restorative nursing aides now. 2. Review of resident 40's electronic medical record (EMR) revealed she was admitted to the facility on 6/23/22. Her diagnoses included Type 2 Diabetes Mellitus (a condition involving disruptions in how the body regulates blood sugar)with diabetic neuropathy	F0688	1. Resident #40, #43 were assessed by therapy for restorative program recommendations. Resident #40 and #43 care plans were updated to address their restorative programming needs. 2. All residents are at risk for deficient practice. All residents identified with limited mobility, contracture risk and decreased range of motion were reviewed for restorative programming needs to ensure restorative programming is implemented by 05/08/2026. 3. Root Cause Analysis: The facility lacked a working restorative program with monitoring to make adjustments to the program as needed, and the program lacked assigned nurse oversight to ensure accountability. Restorative Therapy program log for tracking resident restorative needs was initiated and implemented for assigned nurse designee oversight. DON or designee will educate on restorative therapy, delivery of Restorative therapy according to care plan and documentation by 05/08/2026. Those not in attendance at education sessions will be educated prior to their next shift worked. 4. DON or designee will complete audit of 5 residents for restorative therapy completion and documentation, including documenting resident participation, refusals, and follow-up. Audits will be completed weekly x6 weeks then monthly x2 months. DON or Designee will present audit findings monthly in QAPI meeting for progress review and recommendations.	05/08/2026

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F0688 SS = E	<p>Continued from page 56 (nerve damage that leads to weakness, numbness or tingling in one or more parts of the body), acquired absence of left leg above the knee (amputation), adjustment disorder with depressed mood, and stage 4 (severe) chronic kidney disease (a progressive kidney disease that reduces the kidneys ability to remove waste and keep the blood pressure normal), for which she required dialysis treatments three times per week.</p> <p>A 2/3/26 health status note indicated that the physician had ordered the staff to "encourage participation in restorative activities..."</p> <p>A 3/25/26 physician's order indicated staff were to "Encourage patient to participate in restorative activity 3x [three times] weekly- Complete progress note when completed every day shift."</p> <p>Her 4/31/25 revised care plan included a focus area that resident 40 "will participate in restorative therapy," with a goal that she would "maintain her current functional ability." Interventions were "per therapy and nursing recommendation of AROM [active range of motion]".</p> <p>Her 2/25/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated she was cognitively intact.</p> <p>Her most recent quarterly 2/25/26 Minimum Data Set (MDS) assessment indicated she had a functional limitation in range of motion in one lower extremity (hip, knee, ankle, foot) and one upper extremity (shoulder, elbow, wrist, hand), and had received two days of active range of motion Restorative Nursing Programs during the seven day look back period (the time period over which the resident's condition or status is captured by the MDS assessment).</p> <p>3. Review of resident 40's 12/15/25 through 3/28/26 restorative nursing program, lower extremity exercise task documentation revealed it was documented on nine days that resident 40 was "not available," and on four days, resident 40 had refused. Eight days were documented as "Not Applicable." Resident 40 received restorative lower extremity exercises on 2 days between 12/15/25 and 3/28/26.</p> <p>Review of resident 40's 1/1/26 through 3/31/26 restorative nursing program, kinetic bike exercise documentation revealed it was documented on nine days that resident 40 was "not available," and on five days, resident 40 had refused. Six days were documented as</p>	F0688		

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F0688 SS = E	<p>Continued from page 57 "Not Applicable." Resident 40 received restorative kinetic bike exercises on four days between 1/1/26 and 3/31/26.</p> <p>4. Observation and interview on 3/30/26 at 2:15 p.m. with resident 43 in her room revealed that she used an iPad that translated conversations from her native language to English. She used a power wheelchair and had limited use of her upper and lower extremities. She participated in physical therapy when she admitted to the facility and was discharged from physical therapy services to a restorative program. She was upset that she had not been receiving her exercise program and had complained about that to director of rehab (DOR) MM. She was well informed about the exercise program that had been set up for her. She stated that no one came to get her for the exercises and felt that she was losing her strength and her ability to stand and transfer.</p> <p>5. Review of resident 43's EMR revealed she was admitted to the facility on 7/21/25. Her diagnoses included Rheumatoid Arthritis (a chronic disease that causes pain, swelling, and stiffness in joints in both the upper and lower extremities), polyneuropathy (nerve damage to many nerves throughout the body), and she had sustained fractures to her right lower leg and foot.</p> <p>Her 1/8/26 BIMS assessment score was 15, which indicated she was cognitively intact</p> <p>Her most recent modification of the quarterly 1/8/26 MDS assessment indicated she had a functional limitation in range of motion in one lower extremity (hip, knee, ankle, foot and she had received no restorative nursing exercise programs.</p> <p>Her 1/30/26 care plan included a focus area that resident 43 "will participate in a restorative therapy program," with a goal that she would "maintain her current functional abilities." Interventions were "per therapy and nursing recommendation," "Active ROM [range of motion], sitting exercises 3# [pound] green t-band [TheraBand], trunk exercises x 15 reps [repetitions]," and "Transfers: standing with walker up to 10 min [minutes].</p> <p>6. Review of resident 43's 1/26/26 through 3/30/26 restorative nursing program lower extremity exercise task documentation revealed that on ten days, resident 43 had refused. Four days were documented as "Not Applicable." There was no documentation that resident</p>	F0688		

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F0688 SS = E	<p>Continued from page 58 43 had received lower extremity exercises or had stood with her walker for ten minutes between 1/26/26 and 3/30/26.</p> <p>7. Interview and review of residents 40 and 43's Restorative Nursing Program Transfer Forms with on 3/30/26 at 3:03 p.m. with DOR MM and physical therapy assistant (PTA) NN revealed that the therapy department made written recommendations to the restorative nursing program on those forms and that director of nursing (DON) B would set up those programs. They expected that restorative aide (RA) OO and RA PP would complete those restorative exercise programs with the residents.</p> <p>Resident 40 was to receive upper and lower extremity exercise programs three to six times per week using an "arm bike," a lower extremity "kinetic" recumbent bike, five-pound weights, and green exercise bands.</p> <p>Resident 43 was discharged from physical therapy around 1/26/26. She was to begin a restorative nursing lower extremity exercise program three to six times per week that included standing for ten minutes with her walker, exercises with a three-pound weight, and green exercise bands. It was noted that she did not like to use the exercise bikes.</p> <p>8. Interview and review of residents 40 and 43's restorative documentation on 3/31/26 at 9:01 a.m. with restorative aide (RA) OO revealed that she and RA PP provided restorative exercise programs to approximately 44 residents who resided at the facility. Each resident was scheduled to receive restorative exercises for 15 minutes seven days a week. Some days, she and RA PP worked together, but they were scheduled to work alternating weekends and had different days off, so there were several days when one RA was scheduled. It was impossible to see all 44 residents when one RA was working, but they did the best they could.</p> <p>Some residents could get to and from the restorative therapy room independently, and others required assistance to get to the restorative exercise room. They could not leave the residents alone in that room, and getting residents to and from the exercise room was challenging. She felt that there were residents who participated in restorative exercise programs more than others because they were ready for their exercises at their scheduled times, could get to the room independently, and enjoyed exercising. Some residents were known to refuse, and when they were busy, they had to prioritize the residents who were known to</p>	F0688		

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F0688 SS = E	<p>Continued from page 59 participate.</p> <p>She felt that resident 40 preferred to complete her restorative exercises with RA PP, was known to refuse, and was often unavailable because she attended her dialysis treatments three times a week. She was unsure of the last time she had completed resident 40's restorative exercises with her.</p> <p>RA OO stated that resident 43 was scheduled to receive restorative exercises daily, but that she had not completed restorative exercises with resident 43 in over a month. She thought that RA PP may have been assisting resident 43 with her restorative exercise program.</p> <p>9. Interview by phone on 3/31/26 at 10:44 a.m. with RA PP revealed that she and RA OO provided restorative exercises seven days a week to residents who were listed as participating in restorative nursing exercise programs. There were more residents than could be seen each day, but they tried to accommodate all of the residents' schedules and preferences. Some residents participated regularly, others would refuse, would be unavailable due to medical appointments, or were more difficult to get to the exercise room.</p> <p>She was not allowed to be alone with resident 40, and resident 40 had to complete her exercise program in the main therapy room. It was difficult to get resident 40 to the main exercise room when the exercise bike was available, another staff member was present, and resident 40 was not at her dialysis appointments. She did not recall when she had last seen resident 40 for her restorative exercises program.</p> <p>Resident 43 had refused to complete her restorative exercise program with RA PP "once or twice." RA PP thought that RA OO was assisting resident 43 with her restorative program. She was unsure of the last time resident 43 had been offered restorative exercises.</p> <p>10. Interview on 3/31/26 at 12:17 p.m. with DON B and regional nurse consultant M regarding the provider's restorative nursing program revealed that RA PP was recently hired, and the nurse who was previously in charge of that program was on a medical leave from the facility. DON B had been overseeing the restorative nursing program and expected that restorative exercises be offered and provided to all residents who currently had a written program for at least 15 minutes per day. She was aware that RA OO and RA PP had been having some</p>	F0688		

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F0688 SS = E	Continued from page 60 difficulty providing the program to all of the residents as scheduled. They confirmed that resident 40 had received a total of seven days of restorative exercises since 12/15/25, and that it did not appear that resident 43 had received any restorative exercises since 1/26/26. They were unaware that residents 40 and 43 had concerns about not receiving their restorative exercise programs. 11. Review of the provider's revised 11/18/25 Restorative Nursing policy revealed "Restorative Nursing Program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental and psychosocial functioning... A decision to implement a Restorative nursing program can be made...at any time the services are indicated... For a specialty program, restorative staff will be trained in the techniques that promote resident participation in the activity."	F0688		
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: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, interview, and policy review, the provider failed to ensure resident safety and accident prevention when: *A staff member safely transferred one of one sampled resident (53), who needed to be transferred with the use of a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) according to that resident's care plan by one of one certified nursing assistant (CNA) VV, who attempted to transfer the resident without using the stand lift. That failure	F0689	1. Residents #53 and #16 were reassessed for fall risk and their care plans were reviewed and updated to reflect the residents' transfer needs. The unsecured chemical was removed from the Tub room area and placed in a secured area. The unlabeled chemical was removed and disposed of 03/30/26. Unsupervised housekeeping cart with unsecure chemicals was secured. Housekeeper CC was educated on safe and secure chemical storage on 03/30/26. 2. All residents are at risk for deficient practices. All care plans for residents identified to be at risk for falls were reviewed to ensure transfer needs interventions are up to date and accurate. All housekeeping carts and tub rooms were checked on 04/24/26 and no chemicals were unsecured or unlabeled. 3. Root Cause Analysis: The facility had a system failure caused by lack of staff understanding of chemical storage requirements and a lack of staff consistently following education and monitoring interventions to ensure safe resident transfers. The administrator, DON, and interdisciplinary team, in collaboration with the medical director,	05/08/2026

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F0689 SS = G	<p>Continued from page 61</p> <p>resulted in the resident sustaining a skin tear on his left forearm and a bump on his head, requiring him to be sent to the emergency department (ED), where a CT scan (a series of x-ray images taken from different angles used to produce three dimensional images of bones, organs, or soft tissues) revealed a subdural hematoma (a life-threatening collection of blood between the brain's surface and outer covering).</p> <p>*One of one sampled resident (16) was not safely transferred with the use of a sit-to-stand lift according to that resident's care plan, which placed her at risk for harm or injury.</p> <p>*Chemicals were not securely stored away from resident access in one of three bathtub rooms, and one of one housekeeping carts was left unattended in the main dining area with residents present by housekeeper CC.</p> <p>Findings include:</p> <p>1. Review of the 3/4/26 SD DOH FRI revealed that on 3/4/26 at around 3:15 p.m., CNA VV was transferring resident 53 from the toilet to his wheelchair. Resident 53's legs gave out and resident 53 was lowered to the floor, hitting the back of his head against the fall. Resident 53's care plan stated that resident 53 should have been transferred using a sit-to-stand lift [a mobility device that assist patients to transition from sitting to standing]. CNA VV's employment was suspended during the investigation of the fall.</p> <p>Resident 53 was assessed by nursing staff, and a skin tear was found on resident 53's left forearm. There was a bump on the back of resident 53's head. Resident 53's blood pressure and pulse were elevated. Due to resident 53's history of using blood thinning medications and elevated blood pressure, he was sent to the ED for further evaluation. Resident 54 had a CT scan of his head and cervical spine [neck] in the ED. Results of the head CT revealed a subdural hematoma. CNA VV's employment was terminated for not following resident care plans after being educated multiple time.</p> <p>2. Review of resident 53's electronic medical record (EMR) revealed that he was admitted to the facility on 10/17/25. He had medical diagnoses that included hemiplegia [paralysis of one side caused by brain damage] following cerebral infarction [stroke] of the left side. On 3/10/26, his Brief Interview for Mental Status (BIMS) score was 9 (indicating severe cognitive impairment). His care plan stated that he was to transfer with 1 person using a stand-lift.</p>	F0689	<p>will review, revise, and/or create policies and procedures that address fall prevention and accident hazards, including by not limited to the safe use of mechanical lifts, providing individualized accident prevention interventions as directed in the residents' care plans and storing chemicals in a secure manner that prevents access to chemicals to decrease potential harm or injury. Education and training will be provided for all staff about their roles, responsibilities, and assigned tasks regarding accident prevention and resident safety. Competencies of staff knowledge and implementation of all aspects of the education provided will be conducted by 05/08/26. Those not in attendance at education sessions will be educated prior to their next shift worked.</p> <p>4. DON or designee will audit staff transferring 5 residents with fall prevention interventions to ensure they are transferred according to their care plans weekly x6 weeks, then monthly x2 months. DON or Designee will present audits monthly in QAPI meeting for further review progress and recommendations. Administrator or Designee will audit 4 random areas for safe chemical storage weekly x6 weeks, then monthly x2 months. Administrator or Designee will present audit findings monthly in QAPI meeting for progress review and recommendations</p>	

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F0689 SS = G	<p>Continued from page 62</p> <p>3. Interview on 3/31/26 at 12:30 with director of nursing (DON) B and regional nurse consultant (RNC) M revealed that both were in the facility on the day of the incident. DON B revealed that CNA VV had received education on the morning of 3/4/26 regarding the importance of following resident care plans. DON B reported that when she interviewed CNA VV after the incident, CNA VV acknowledged being educated that morning on the importance of following resident care plans. DON B stated that when she asked CNA VV why the care plan was not followed, CNA V told DON B that she could complete the transfer faster without using the stand-lift. DON B expected CNAs to follow each resident's care plans to help prevent falls and injuries.</p> <p>4. Review of the provider's 3/17/26 FRI regarding resident 16 revealed resident 16's family member reported concerns related to the quality-of-care including reports that resident 16 may have been injured during a transfer involving a mechanical lift operated by CNA/CMA R.</p> <p>Resident 16 used a sit-to-stand lift since she was admitted to the facility on 3/2/26 and was changed to a full body lift (a mechanical lift and sling used to lift a person's full body) due to a decline in her health on 3/18/26.</p> <p>5. Review of resident 16's EMR revealed she admitted to the facility on 3/2/26.</p> <p>Her diagnoses included senile degeneration of the brain (progressive loss of cognitive function and brain tissue associated with aging) and her 3/6/26 BIMS assessment score was 4, which indicated her cognition was severely impaired.</p> <p>Resident 16's 3/3/26 care plan indicated she was to be transferred with the use of a sit-to-stand lift, which was revised on 3/18/26 to indicate she transferred with the use of a full body mechanical lift.</p> <p>Her 3/4/26 lift assessment completed by RN CCC indicated she could not bear at least 50 percent of her weight on one leg, was unable to sit upright without physical assistance, and was not able to follow simple instructions. That assessment stated that if a resident could not do one of the criteria listed, they were not a candidate to transfer with the use of a sit-to-stand lift.</p>	F0689		

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F0689 SS = G	<p>Continued from page 63</p> <p>Resident 16 was documented as not being able to do three of the criteria but RN CCC indicated within the summary and plan portion of the lift assessment that resident 16 was to use a sit-to-stand lift for bed to chair transfers.</p> <p>Review of resident 16's skin assessments revealed there was no documentation of bruising or purple discolorations on resident 16's arms or legs on those assessments.</p> <p>6. Interview on 3/25/26 at 2:50 p.m. with CNA/CMA R revealed administrator A and DON B told her that resident 16's family member had expressed some concerns related to resident 16 being left in her night gown in bed until 2:30 p.m., transfers, and sores on her buttock.</p> <p>CNA/CMA R stated she was not assigned to assist resident 16 with her cares prior to 3/17/26 when resident 16's family member expressed her concerns related to the care her mother had received by the staff.</p> <p>On 3/17/26 resident 16's family member asked her to get resident 16 out of bed. The pocket care plan indicated resident 16 was a pivot transfer (when assisted to a standing position, the resident then turns their body to move to another surface) with the assistance of one staff member.</p> <p>Resident 16's family member told her resident 16 was a pivot transfer with the assistance of two staff members. CNA/CMA R transferred resident 16 with resident 16's family member by putting their arms under resident 16's arms and pivot transferring her from her bed to the bath chair.</p> <p>While they were transferring resident 16 from the bed to the bath chair resident 16 would not follow directions or move her feet. CNA/CMA R stated she held resident 16 up while she quickly pulled the bath chair under resident 16 and sat her down.</p> <p>Resident 16's family member had not expressed any concerns to her but had spoken with LPN Y that day.</p> <p>7. Interview on 3/26/26 at 10:15 a.m. with CNA/CMA V revealed she used the resident's Kardex (a report of the resident's care needs and interventions) or the pocket care plan (a document that identifies residents' care needs and interventions) to determine how a</p>	F0689		

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F0689 SS = G	<p>Continued from page 64 resident transfers.</p> <p>She asked the unit managers to update the pocket care plans at times because it was not kept up to date with each resident's care needs.</p> <p>8. Review of the blue hallway's undated pocket care plan indicated resident 16 was to be transferred with a full body mechanical lift with a full body sling.</p> <p>9. Interview on 3/30/26 at 2:08 p.m. with resident 16's family member on the phone revealed she spoke with administrator A about her concerns related to the quality-of-care resident 16 received from the staff.</p> <p>She came to visit resident 16 one day around 2:30 p.m. and found her lying in her bed, in her pajamas with food on her face and clothing. She stated the staff did not know how to "lift" her mother. They had not used a gait belt (a waist strap gripped as support for safe mobility and transfers) when they transferred her.</p> <p>Resident 16's daughter stated she had assisted staff members with pivot transferring resident 16 at times.</p> <p>At times the staff were using the sit-to-stand lift to assist her mother with transfers, but she recently had been changed to a full body lift. One time she had witnessed a CNA place the sit-to-stand sling behind resident 16 while she was seated at the side of the bed and then the CNA left her mother to go out into the hallway to get the sit-to-stand mechanical lift and her mother fell backwards into the bed.</p> <p>Resident 16's daughter felt the bruises on her mother's arms and legs were related to the sit-to-stand lift. Resident 16's daughter stated she was not aware of resident 16 having any falls since her admission to the facility.</p> <p>When resident 16 admitted to the facility on 3/2/26 a staff member had told her that resident 16 was a pivot transfer with the assistance of one staff member. Resident 16's daughter told that staff member that resident 16 would require at least two staff members to assist her with a pivot transfer because she used a mechanical lift in the facility she previously lived in.</p> <p>Resident 16 was designated to be transferred with a sit-to-stand lift after that conversation, but some staff continued to transfer resident 16 by pivot</p>	F0689		

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F0689 SS = G	<p>Continued from page 65 transfer with the assistance of two staff members and did not use a gait belt.</p> <p>10. Observation on 3/30/26 at 3:30 p.m. of resident 16 in her room revealed she was lying in bed covered with blankets with her right arm outside the blankets. On her right arm were round purple discolorations of various sizes.</p> <p>11. Interview on 3/31/26 at 8:56 a.m. with RA PP revealed she referred to the resident's Kardex or the pocket care plan to determine how to care for each resident. The pocket care plan and the residents' Kardex would include how that resident transfers. She stated the pocket care plans are not always kept up to date.</p> <p>12. Interview on 3/31/26 at 10:02 a.m. with LPN Y revealed she had notified resident 16's daughter of resident 16's pressure ulcer (skin and/or underlying tissue injury from prolonged pressure) on her left buttock but did not speak with her about any of her other concerns.</p> <p>13. Review of resident 16's EMR and interview on 3/31/26 at 10:45 a.m. with DON B revealed resident 16 used a sit-to-stand lift to transfer since she admitted to the facility on 3/2/26.</p> <p>She was changed to a full body mechanical lift after her daughter brought forward the concern she had possibly been injured during a transfer with a mechanical lift and a 3/17/26 lift evaluation was completed and indicated she was not a candidate for a sit-to-stand lift.</p> <p>Resident 16's daughter had told DON B that family members had been pivot transferring resident 16 but she was not aware the staff had been transferring resident 16 that way.</p> <p>DON B stated she was not aware of any bruises on resident 16 and stated there was no documentation of bruises on resident 16's skin assessments. She was not aware there were bruises on resident 16's arms and stated that if they were there they would be of an unknown origin.</p> <p>DON B verified resident 16's initial lift assessment completed by RN CCC indicated she was not a candidate</p>	F0689		

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F0689 SS = G	<p>Continued from page 66 for a sit-to-stand lift for transfers by the established criteria in the assessment, but RN CCC documented in the summary at the end of the assessment that resident 16 was to use a sit-to-stand lift for transfers.</p> <p>14. Interview and review of resident 16's EMR and the facility's investigations related to resident 16's family member's concerns on 3/31/26 at 1:41 p.m. with administrator A revealed resident 16's family member reported her concerns related to the care resident 16 was receiving on 3/17/26. One of the concerns that was expressed by resident 16's family member was bruising related to an injury sustained by a mechanical lift, but she was unable to expand on that information.</p> <p>A skin assessment was completed by LPN Y after resident 16's family member brought forward her concerns.</p> <p>Administrator A did not recall resident 16's family member talking to her about the staff members using a stand pivot method for transferring her mother. She was not aware resident 16's 3/4/26 lift assessment completed by RN CCC indicated resident 16 was not a candidate for a sit-to-stand lift but was care planned to use a sit-to-stand lift despite the assessment results. Administrator A expected the staff to follow residents' care plans when they assisted each resident with their care needs.</p> <p>15. Review of the provider's 5/20/2022 CNA job description revealed "In keeping with our organization's goal of improving the lives of the Guests we serve, the Certified Nursing Assistant (C.N.A.) plays a critical role in providing superior customer service and nursing care to all Guests. The C.N.A. safeguards the health, safety, and welfare of all Guests under their care by following applicable laws, regulations, and established nursing policies and procedures. Essential functions of the CNA included "4. Attends to individual needs of all Guests in regards to incontinent care, transferring, ambulation, range of motion, communication and other needs. 5. Provides care that maintains Guest's skin integrity to prevent pressure ulcers, skin tears and other damage by changing incontinent Guests, turning, repositioning immobile Guests and by applying moisturizers to fragile skin and other areas. 7. Must be knowledgeable of individual care plans and support the care planning process by providing supervisors with specific information and observations of the Guest's needs, preferences and report any behavioral changes."</p>	F0689		

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F0689 SS = G	<p>Continued from page 67</p> <p>16. Review of the provider's 5/14/2025 care plans policy revealed "Policy: Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence." "3. Care planning is consistently in process; it begins the moment the resident is admitted to the facility and doesn't end until discharge or death." "5. The physician's orders (including medications, treatments, labs, and diagnostics) in conjunction with the resident's care plan constitute the total 'plan of care'."</p> <p>17. Observation on 3/25/26 of the blue hallway bathtub room revealed the tub room door was open and there were no staff members in the bathtub room. On top of the bathtub was a pink crate that contained two spray bottles. One spray bottle was labeled Multi-Surface Peroxide (a multi-surface cleaner). The label on that bottle indicated it, "Causes skin irritation" and "Causes serious eye damage".</p> <p>The second spray bottle was not labeled with what was in the bottle and it was two-thirds full of an unidentified liquid</p> <p>18. Observation on 3/30/26 at 1:00 p.m. of the blue hallway bathtub room revealed the bathtub room door was open and there were no staff members in the bathtub room or near the entrance of the bathtub room. The two spray bottles were in the pink crate on top of the bathtub.</p> <p>19. Observation and interview on 3/30/26 at 1:54 p.m. of the main dining room revealed there was an unsupervised housekeeping cart in the dining room. There were two residents sitting at a table in the dining room and no staff members were present. A bottle of toilet bowl cleaner was on the housekeeping cart with the spout open.</p> <p>The door on the housekeeping cart where the cleaning chemicals were stored was unlocked. In the lockable compartment was a bottle of Multi-Surface Peroxide cleanser and Micro Kill foaming disinfectant cleaner. The keys to unlock the cart were on the top of the cart.</p> <p>At 2:04 p.m. administrator A entered the main dining room and verified the chemicals were not secured away from residents' access. She called on her walkie-talkie</p>	F0689		

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F0689 SS = G	<p>Continued from page 68 and housekeeper CC entered the main dining area.</p> <p>Housekeeper CC acknowledged the housekeeping cart was hers and she had left it unlocked and unattended, and the toilet bowl cleaner was stored on her cart in a location that could not be locked.</p> <p>20. Observation on 3/30/26 at 3:34 p.m. of the blue hallway bathtub room revealed the door was open; there were no staff members in the bathtub room or near the entrance to the bathtub room. The two spray bottles were in the pink crate on top of the bathtub.</p> <p>21. Observation on 3/31/26 at 8:09 a.m. of the blue hallway bathtub room revealed the door to the bathtub room was open with no staff members in the room. The two spray bottles in the pink crate were on top of the bathtub.</p> <p>22. Observation and interview on 3/31/26 at 8:18 a.m. with CNA WW revealed she had given residents' baths in the blue hallway bathtub room. She verified there were two spray bottles on top of the bathtub but stated she did not know what they were used for and she acknowledged the door on the blue hallway bathtub room was to remain closed to prevent residents from accessing the room unsupervised.</p> <p>23. Interview on 3/31/26 at 8:32 a.m. with RN T revealed the door to the bathtub rooms were to be closed and locked to prevent residents from entering the room and tripping as well as to prevent them from being exposed to unsecured chemicals.</p> <p>24. Interview on 3/31/26 at 10:45 a.m. with DON B revealed she did not know what the chemical spray bottles in the blue hallway bathtub room were used for. She expected the door to the bathtub room to be closed to prevent residents from entering when eh room was unattended and chemicals were present.</p> <p>She acknowledged the chemicals in the blue hallway bathtub room were unsecured with the door open and posed a potential risk for a resident to be exposed or have access to those chemicals. She expected all chemicals to be labeled with what was in the bottle.</p> <p>25. Observation and interview on 3/31/26 at 11:25 a.m.</p>	F0689		

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F0689 SS = G	Continued from page 69 with regional nurse consultant (RNC) M revealed in the blue hallway bathtub room revealed she verified there were two spray bottles in the pink basket on top of the bathtub. One of the bottles was Multi-Surface Peroxide cleanser and the other bottle was unlabeled. RNC M smelled the liquid in the unlabeled spray bottle and verified the bottle did not contain water, but she was unsure what the liquid was. 26. Interview on 3/31/26 at 1:41 p.m. with administrator A revealed she did not know the bathtub door in the blue hallway was left open. She stated the bathtub room was to be closed, locked, and accessible only by staff through a code pad on the door. She expected all chemicals to be stored in their original labeled container in a secure location to prevent a resident's access to the chemical.	F0689		
F0697 SS = G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to assess and manage pain for one of one sampled resident (78) who showed signs of having pain. Findings include: 1. Observation on 3/25/26 at 9:15 a.m. in the hallway by resident 78's room revealed he was being wheeled to his room by (name of hospice agency) certified nursing assistant (CNA) YY after receiving a shower. Resident 78 could be heard moaning and his face was grimacing suggesting he was in pain. CNA WW wheeled resident 78 into his room and then closed the door to provide cares to resident 78. Over the following several minutes, resident 78 could be heard screaming outside his closed bedroom door. 2. Review of resident 78's electronic medical record	F0697	1. Resident #78 was reassessed for pain management needs and related interventions were updated on resident's care plan. 2. All residents are at risk for deficient practice. All residents will be interviewed for effective pain management interventions. The physician will be notified of any identified pain management concerns for review and recommendation. 3. Root Cause Analysis: The facility had a systemic failure due to lack of education and all staff understanding to recognize and respond to non-verbal signs of pain in a cognitively impaired resident and adequate use of PAINAD scale to assess pain. The administrator, DON, and interdisciplinary team, in collaboration with the medical director, consultant pharmacist, and governing board, will review, revise, and/or create policies and procedures that address pain management for all residents and specifically residents receiving hospice services, including utilizing appropriate communications tools for assessing a resident's presence and/or level of pain, implementing pharmacological and non-pharmacological pain interventions, reviewing the effectiveness and use of scheduled and as needed (PRN) pain medications to ensure adequate and effective pain management.	05/08/2026

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F0697 SS = G	<p>Continued from page 70 (EMR) revealed that he was admitted to the facility on 1/25/22. Resident 78's medical diagnoses included Alzheimer's Dementia, Displaced fracture of right femur, and Polyneuropathy (neurological condition resulting from widespread damage of peripheral nerves, often causing numbness, tingling, pain, and muscle weakness). Resident 78's 1/5/26 Brief Interview for Mental Status (BIMS) assessment score was not completed. Question one of the assessment was "Should Brief Interview for Mental Status be assessed?" Answer was "0. No (resident is rarely/never understood)." (meaning the resident does not have the cognitive ability to complete the assessment).</p> <p>Resident 78 was admitted to Hospice (a specialized comfort-focused form of care for individuals with a terminal illness. This care prioritizes quality of life, pain management, and emotional/spiritual support the patient and family) on 12/23/25.</p> <p>Resident 78's medication orders revealed that he received scheduled acetaminophen (mild pain reliever) and Tramadol (opioid for moderate to moderate/severe pain). There was an order for PRN (as needed) Morphine (a narcotic pain medication) 5 mg (milligrams) "every two hours as needed for pain or dyspnea (shortness of breath)."</p> <p>Resident 78's electronic medical record revealed that on 3/25/26, a medical diagnosis of Pseudobulbar Affect (a neurological condition characterized by sudden, uncontrollable, and inappropriate episode of laughing or crying that do not match a person's actual inner emotions) was added to his list of diagnoses.</p> <p>3. Interview on 3/25/26 at 9:24 a.m. with CNA YY revealed "It's tough to determine if he [resident 78] is actually in pain because he has a lot of anxiety. He has a lot of lower body rigidity [involuntary, sustained stiffness or tension of muscles, causing discomfort and reduced range of motion]."</p> <p>4. Observation on 3/25/26 at 11:10 a.m. outside of resident 78's room revealed that resident 78 could be heard outside of his room with the door closed moaning and yelling. CNA XX was observed walking with licensed practical nurse (LPN) H to resident 78's room and gave him PRN Morphine.</p> <p>5. Interview on 3/25/26 at 3:50 p.m. with LPN H revealed that she felt resident 78 was often feeling pain when he was moved and transferred. She did not feel that [name of hospice agency] was managing resident 78's pain appropriately. She reported that she</p>	F0697	<p>Education and training will be provided for all staff on their roles, responsibilities, and assigned tasks related to pain management. Competencies of staff knowledge and implementation of all aspects of the education provided will be conducted by 05/08/26. Those not in attendance at education sessions will be educated prior to their next shift worked.</p> <p>4. DON or designee will audit 5 residents for pain management needs to ensure pain management is effective and the resident's care plan is up to date to address those needs weekly x 6 weeks then monthly x2 months. DON or Designee will present audit findings monthly in QAPI meeting for progress review and recommendations.</p>	

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F0697 SS = G	<p>Continued from page 71 had made her unit manager aware of her concerns about resident 78's pain.</p> <p>6. Interview on 3/26/26 at 10:09 a.m. with CNA/CMA BB revealed that she had provided cares for resident 78 for over a year. She felt that resident 78's behaviors were tough to interpret at times. "He does have different noises. Some are happy, neutral, and crying." She reported that resident 78 will sometimes answer "yes or no" if he was in pain, but does not answer on a 10 point pain scale (used to determine someone's pain on a scale of 1 through 10). She stated, "he is very rigid, and there probably is some pain when he is moved." She also felt it would be a good idea to medicate resident 78 before frequent movement.</p> <p>7. Observation on 3/26/26 at 10:21 a.m. outside of resident 78's room with the door closed revealed that he could be heard making moaning and yelling sounds while the staff were in the room providing cares for him.</p> <p>8. Interview on 3/26/26 at 10:29 a.m. with CNA ZZ after exiting resident 78's room revealed that when asked if she felt resident 78 was experiencing pain when cares were being provided, she responded "I just started last week. I'm not sure if he is in pain." She did not feel she was able to "judge his emotions yet."</p> <p>9. Interview on 3/26/26 at 11:07 a.m. with registered nurse (RN) unit manager J regarding resident 78's diagnosis of Pseudobulbar Affect revealed that there was conversation between the staff about resident 78's behaviors that led to the review of his EMR that revealed he had a previous diagnosis of Pseudobulbar Affect and "it must have dropped off of his list of diagnoses." The resident's primary care provider was faxed to ask if it was appropriate to add the diagnosis of Pseudobulbar Affect to his list of diagnoses. She reported that she was not made aware by staff that resident 87 was experiencing increased pain.</p> <p>10. Interview on 3/26/26 at 11:33 a.m. with CNA AAA revealed that she had provided cares for resident 78 for about a year and a half. She felt that resident 78 cries out when he expresses pain. She reported that resident 78 does not always cry when he is being transferred. She stated that earlier in the morning, resident 78 was crying when she took him to the dining room for breakfast and she felt he was experiencing pain, and she reported that to the nurse, LPN O.</p> <p>11. Interview on 3/26/26 at 12:41 with LPN O revealed that she felt resident 78 was tough to read. "Sometimes</p>	F0697		

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F0697 SS = G	<p>Continued from page 72 his laugh sounds like a cry." "Usually if he is in pain, I try the morphine. If that doesn't help, I try the Ativan [anxiety medication]. He seems really anxious when being transferred. I don't know that he is in pain."</p> <p>12. Review of resident 78's medication administration record (MAR) revealed that LPN O did not administer morphine that day or during March 2026.</p> <p>13. Observation on 3/30/26 at 3:26 p.m. with CNA/Staff coordinator AA and CNA/CMA BB changing resident 78's incontinence (involuntary urine or bowel leakage) brief revealed resident 78 appeared calm before the staff moved him. When resident 78 was turned onto his right side, he was constantly grimacing. He began to moan "ga ga ga ga ga ga ga ga." His face was red with a grimace and he appeared to be in pain. The resident responded similarly when he was rolled onto his left side. CNA/Staff coordinator AA and CNA/CMA BB attempted to hold resident 78's hand and talk to him while changing his incontinence brief, but that did not seem to help.</p> <p>14. Interview on 3/30/26 at 4:28 p.m. with LPN H and RN P revealed that it was their opinion that resident 78's pain was not being managed appropriately. LPN H was told by DON B that LPN H should only be administering resident 78's PRN morphine when he had extreme pain. LPN H reported that she felt resident 78 was sometimes in extreme pain, so she treated it with the ordered morphine.</p> <p>LPH H reported that resident 78 was not cognitively intact and his pain could not be appropriately assessed using the 10 point pain scale. She used the PAINAD [Pain Assessment in Advanced Dementia. An observational tool that assesses 5 behaviors; breathing, negative vocalizations, facial expressions, body language, and consolability] assessment to assess resident 78's pain and treated his pain according to that assessment.</p> <p>15. Observation and Interview on 3/31/26 at 9:25 a.m. with resident 78 near the nurse's station revealed he was well dressed and groomed. When asked if he was experiencing pain, he did not reply. When asked if he could describe his pain on a scale of 0-10, with 0 being no pain at all, and 10 being the worst pain he had ever experienced, he did not respond.</p> <p>16. A review of resident 78's documented pain rating assessments revealed that between 3/20/26 and 3/31/26, there were 51 pain assessments documented. 27 assessments were documented using the 10 point pain scale, and 24 assessments were documented using the</p>	F0697		

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F0697 SS = G	Continued from page 73 PAINAD scale. 17. Interview on 3/31/26 at 10:06 a.m. with DON B revealed that she was aware of resident 78's recent diagnosis of Pseudobulbar Affect. She stated that after surveyors had started to question if resident 78 was experiencing pain, it caused the staff to look to see if there may be other reasons for resident 78's behaviors. She reported that after a review of resident 78 VA (Veterans Administration) records, the staff found that the resident was diagnosed with Pseudobulbar Affect before being admitted to the facility. 18. Review of resident 78's VA discharge documentation from 1/25/22, before admission to the facility, revealed there was no diagnosis of Pseudobulbar Affect listed in his medical diagnoses. 19. Interview on 3/31/26 at 2:25 p.m. with RNC M revealed that after requesting documentation of resident 78's original documentation of Pseudobulbar Affect, RNC M stated "The Pseudobulbar Affect diagnosis came from me." She reported that resident 78 was admitted initially under an inappropriate dementia diagnosis. She admitted that resident 78 was never diagnosed with Pseudobulbar Affect before 3/25/26. She did not feel that the 10 point pain scale was appropriate for a resident whose cognition was not intact and typically did not provide more than one word responses. 20. Review of the providers 4/28/25 pain management policy revealed "1. The pain management program is based on a facility wide commitment to resident comfort. 2. "Pain Management" is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical conditions and established treatment goals." "Recognizing Pain: 1. Observe the resident (during rest and movement) for physiologic and behavioral (non-verbal) signs of pain. Possible Behavioral Signs Of pain: A. Verbal expression such as groaning, crying, screaming. B. Facial expressions such as grimacing, frowning, clenching of the jaw, etc.; C. Changes in gait, skin color and vital signs; D. Behavior such as resisting care, irritability, depression, decreased participation in usual activities"	F0697		
F0740 SS = D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services.	F0740	"Past Noncompliance - no plan of correction required"	

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F0740 SS = D	<p>Continued from page 74</p> <p>Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, record review, and policy review, the provider failed to ensure the staff followed the care planned interventions for one of one sampled resident (72) identified as requiring all of her care to be provided by two caregivers who expressed distress and reported that one of one certified nursing assistant (CNA) (JJ) was "rough" with the resident when that CNA did not provide the resident's care with another staff member present. This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident.</p> <p>Findings include:</p> <p>1. Review of the provider's 11/16/25 SD DOH FRI revealed that on 11/16/25 at 11:30 a.m., resident 72 reported to licensed practical nurse (LPN) UU that CNA JJ "was rough with her." CNA JJ was suspended pending the results of an investigation.</p> <p>LPN UU completed a skin assessment of that resident, and no new areas of concern or evidence of significant harm or injury were noted.</p> <p>Interviews conducted with staff on duty identified that resident 72 "was screaming after [CNA JJ] went into the room and started helping her [resident 72], then left to get a second person to assist." CNA JJ confirmed that she went into the resident's room alone and assisted [resident 72] with care.</p> <p>Resident 72 had a history of "allegations of staff being rough and is care planned to be cared for in pairs [two people] by staff."</p> <p>CNA JJ "was not following the resident's care plan... and [her employment] was terminated effective 11/18/25." "Staff education was initiated on cares in pairs [care provided by two staff members]. Audits [were]</p>	F0740		

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F0740 SS = D	<p>Continued from page 75 implemented to ensure care in pairs are being followed weekly x4 [for four] weeks." The resident's physician, the police department, and the family were notified.</p> <p>2. Review of resident 72's electronic medical record (EMR) revealed she admitted to the facility on 2/9/22. Her 10/28/22 care plan indicated a focus area of "MANIPULATIVE BEHAVIOR (ALLEGED MISTREATMENT) [Resident 72] may voice allegations of mistreatment or exploitation by caregivers. This behavior appears to be related to feeling [a] loss of independence. Will also exhibit [the] behavior of abusive language."</p> <p>Interventions for that behavior included "Assure [resident 72] that she is safe and secure... prefers caregivers without accents in her room... [resident 72] continues to make accusations against staff of African decent [descent]..."</p> <p>"Implement special care strategies as she will have two (2) caregivers address [her] needs and to observe the entire session. Have supervisory personnel observe care delivery, as [much as] possible and in accordance with privacy and dignity considerations." "Offer staff of Caucasian descent when able."</p> <p>Her 11/16/25 skin evaluation indicated there were no new skin issues observed.</p> <p>3. Observation and interview on 3/24/26 at 3:22 p.m. with resident 72 in her room revealed she did not recall the specific incident on 11/16/25, but indicated that she felt like the staff "Do everything wrong." She stated that every time the staff touched her, they hurt her. She felt like they were trying to "break her bones." She stated that they "always bonked" her on the head when they transferred her. And they "never" positioned her correctly in the bed or in the wheelchair. She did not like her custom wheelchair, her bed, or her door open. She stated she waited hours to be put to bed and that she wanted to be put back to bed. At 3:24 p.m., resident 72's call light was turned on, and at 3:26 p.m., an unidentified staff member entered the room and stated that she would get another staff member to assist her with putting resident 72 back to bed. At 3:28 p.m., CNA U and regional nurse consultant (RNC) L assisted resident 72 back to bed and with her care.</p> <p>This surveyor exited the room while those staff members provided the resident's personal care to maintain the resident's right to privacy. There were no episodes of</p>	F0740		

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F0740 SS = D	<p>Continued from page 76 the resident calling out observed.</p> <p>After that care was provided, the surveyor entered the resident's room and continued the interview. Resident 72 reported that she "liked that one girl," but the other staff member tried to hurt her, went too fast, she felt like her fingers were broken, and she had not been positioned comfortably in bed. She declined the offer to inform the staff that she was uncomfortable and to request staff assistance to be repositioned.</p> <p>4. Interview on 3/24/26 at 3:44 p.m. with CNA U regarding resident 72's report of the care she received when assisted to bed during the above observation and interview revealed that resident 72 was to always receive care with two staff present because of the accusations she at times made after receiving care. Resident 72 told inconsistent stories, was manipulative, did not like new staff members, and was known to scream even before some staff members touched her. Resident 72 was very particular about who she allowed to help her. RNC L was not a familiar care provider to resident 72</p> <p>CNA U stated she felt she had a good relationship with resident 72 because the resident liked her, but it was very hard to make the resident happy. She felt that resident 72's reports of events were often "not believable," and that resident 72 had not reported a concern with the care provided when she and RNC L assisted her to bed and had stated that she was comfortably positioned when they left her room.</p> <p>5. Interview on 3/30/26 at 2:42 p.m. with administrator A and DON B regarding resident 72's 11/16/25 report that CNA JJ was rough with her during her care revealed that LPN UU had notified them of the incident on 11/16/25 and administrator A confirmed they immediately suspended CNA JJ, reported the incident to the SD DOH, resident 72's physician, and the resident's power of attorney, and conducted an investigation. They identified that the incident occurred because CNA JJ did not provide resident 72's care with two staff members present, as indicated in her care plan. They provided immediate education to all nursing staff working at that time and initiated ongoing education with all caregiver staff members. They interviewed residents identified as requiring their care to be provided "in pairs" to ensure that two staff members were present when care was provided and implemented weekly audits beginning on 11/21/25. They reviewed those audits in their QAPI program and continue to</p>	F0740		

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F0740 SS = D	<p>Continued from page 77 monitor that nursing staff members are following the residents' care plans related to providing "cares in pairs" for the residents with that intervention identified on their care plan.</p> <p>6. Review of the provider's Abuse and Neglect, Cares in Pairs, and Care Plan, policy staff education initiated on 11/17/25 revealed that all nursing staff were educated about the information in those policies.</p> <p>7. Review of the provider's QAPI notes from 12/10/25 revealed that resident 72's 11/16/25 allegations of abuse were reviewed, and a care plan performance improvement project (PIP) meeting had been scheduled.</p> <p>8. Review of the provider's audits after resident 72's 11/16/25 report revealed the provider completed five audits a week for four weeks to observe if the resident's care plans were followed by the staff members providing the resident's care to ensure care was provided to the residents in accordance with the provider's "cares in pairs" expectations and no further issues were observed. No additional staff education was needed as a result of the audits.</p> <p>9. The provider's implemented actions to ensure the deficient practice does not recur were confirmed on 3/31/26 after record review revealed the facility had followed their quality assurance process, education was provided to all nursing staff regarding expectations for following resident care plans and the resident's identified as requiring "cares in pairs", the provider's care plan policy was reviewed, and audits were completed. Interviews with nursing staff revealed they understood the education provided regarding the resident care plans, and were able to identify residents who required "cares in pairs" both in the resident care plan and with signage posted on the residents' doors. Observations of resident care were conducted on residents requiring "cares in pairs" and confirmed that staff followed the resident care plan, and two staff members were present when indicated in the resident care plan. A QAPI meeting was held on 12/10/25, and the incident regarding resident 72 and the completed audits were reviewed to implement a corrective plan. The audit results will continue to be a part of their QAPI process for review and recommendations as needed.</p>	F0740		

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F0740 SS = D	Continued from page 78 10. Based on the above information, non-compliance at F684 occurred on 11/16/25, and based on the provider's 1210/25 implemented corrective actions for the deficient practice confirmed on 3/31/26, the non-compliance is considered past non-compliance.	F0740		
F0760 SS = G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, observation, and policy review, the provider failed to ensure one of one registered nurse (RN) (F) administered a medication according to the physician's order for one of one sampled resident (44) with a history of heart disease who required the use of the medication to prevent chest pain. Findings include: 1. Interview on 3/24/26 at 9:22 a.m. with resident 44 revealed that he was admitted to the facility about three weeks ago. He was very upset about not receiving his nitroglycerin patch heart medication (a medication patch used to prevent chest pain caused by heart disease) as ordered the previous morning. He stated that he spent the entire day and night worrying that something terrible would happen to him. He asked the day nurse yesterday "three or four times" for that medication and was told he was not the only resident to whom the nurse had to provide medication, that he would receive his medication when the nurse brought it to him, and not to worry about it. Resident 44 stated that he had a "heart attack" in the past, had numerous "stents" (small mesh tubes used to hold open blood vessels) placed, and not receiving his nitroglycerin patch was causing him "a lot of anxiety." He told the evening nurse, when she came to remove the patch on the evening of 3/23/26, that he did not receive that medication at all that day. He stated, "I hope she documented that." He stated that he was at the facility once before last	F0760	1. Resident #44 identified medication error could not be corrected. Resident #44 was assessed for adverse emotional impact and verbalized no emotional concerns, no concerns with medication administration 05/01/2026. 2. All residents are at risk for deficient practice. All residents' Medication Administration Records for the last 30 days will be reviewed for medications being administered per physician order. The physician will be notified of any identified related concerns. 3. Root Cause Analysis: The licensed nursing staff failed to follow medication administration standards including timely administration of medications and appropriate response to resident requests. The administrator, DON, and interdisciplinary team, in collaboration with the medical director and consultant pharmacist, will review, revise, and/or create policies and procedures as necessary to ensure consistent and accurate administration of residents' medications as ordered to ensure no omissions of medications and to mitigate the risks of physical and/or psychosocial harm from not receiving medications as ordered and/or care planned. Those policies and procedures should include staff education and monitoring processes to ensure compliance. Education and training will be provided to all staff who administer medications about their roles and responsibilities regarding medication administration. Competencies of staff knowledge and implementation of all aspects of the education provided will be conducted by 05/08/26. Those not in attendance at education sessions will be educated prior to their next shift worked. 4. DON or designee will audit staff during medication passes for 3 residents weekly x6 weeks, then monthly x 2 months. DON or	05/08/2026

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F0760 SS = G	<p>Continued from page 79 year and felt that the facility was aware of his healthcare needs and should have known that his nitroglycerine patch medication was important not to skip.</p> <p>2. Review of resident 44's EMR revealed he was admitted to the facility on 3/5/26.</p> <p>He previously resided at the facility from 7/9/25 through 7/15/25, was discharged to the hospital due to chest pain, and then went home for several months before being admitted to the facility again this month.</p> <p>His 3/11/26 Brief Interview for Mental Status (BIM) assessment score was 15, indicating that his cognition was intact.</p> <p>A 3/5/26 focus area indicated that resident 44 "has a diagnosis of anxiety." A goal that resident 44 "will not be affected with signs/symptoms of psychosocial stressors, and that his "episodes of anxiety will be relieved in a short period of time with staff intervention."</p> <p>His 7/9/25 care plan indicated a focus area that resident 44 was "at risk for altered cardiovascular function related to atherosclerosis (a disease of the arteries where fatty material deposits on their inner walls), HTN [hypertension (high blood pressure)], PVD [peripheral vascular disease (a progressive narrowing or blockage of blood vessels)], iron deficiency, anemia (not having enough red blood cells to carry oxygen to the body's tissues), unstable angina (a condition in which the heart does not get enough blood flow and oxygen), obesity (overweight), CKD [chronic kidney disease (kidney damage)], and TIA [transient ischemic attack (a brief blockage of blood flow to the brain)]. The 3/5/26 goal indicated that resident 44 "will be free from signs and symptoms of complications of cardiac problems." Interventions included "Administer medications as ordered."</p> <p>There was a 3/6/26 physician's order for Nitroglycerin Transdermal Patch 0.4 milligrams/hour (mg/hr), apply two patches transdermally (to the skin) one time a day and remove per schedule. This was scheduled to be applied each day at 8:00 a.m. and removed each day at 7:59 p.m.</p> <p>Resident 44's March 2026 medication administration record (MAR) indicated that on 3/23/26 at 8:00 a.m., registered nurse (RN) F, administered the Nitroglycerine Transdermal Patches. On 3/23/26 at 7:59</p>	F0760	Designee will present audit findings monthly in QAPI meeting for progress review and recommendations.	

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F0760 SS = G	<p>Continued from page 80 p.m., licensed practical nurse (LPN) G documented, "Per resident patches were not applied this AM [morning]."</p> <p>3. Interview on 3/25/26 at 3:15 p.m. with LPN/unit manager C regarding resident 44's report that he did not receive his physician-ordered nitroglycerin patches on the morning of 3/23/26 revealed that resident 44 told her about that incident today (3/25/26) after he mentioned it to the surveyor. She reported that information to director of nursing (DON) B and administrator A to conduct an investigation.</p> <p>4. Interview on 3/25/26 at 3:18 p.m. with DON B and administrator A revealed LPN/unit manager C reported to them today that resident 44 stated that he did not receive his nitroglycerin patches on the morning of 3/23/26. They identified the nurses who worked that day, and were in the process of interviewing resident 44, RN F, and LPN G.</p> <p>5. Observation and interview on 3/25/26 at 3:21 p.m. with DON B and LPN/unit manager C revealed that LPN C and DON B completed a count of resident 44's Nitroglycerin Transdermal Patches 0.4 mg/hr. There were 22 patches remaining in the box.</p> <p>DON B planned to contact the pharmacy to confirm how many patches had been dispensed. The investigation was ongoing at that point, and she was unsure if resident 44 received all of the ordered doses of his patches at that time.</p> <p>6. Review of resident 44's March 2026 MAR indicated that it was documented that resident 44 received 20 doses (40 patches) of his Nitroglycerin Transdermal Patches 0.4 mg/hr.</p> <p>7. Review of RN F's 3/25/26 written statement revealed, "I tried to give him [resident 44] his nitro patch in the dining room but he said later in my room and I gave them to him later when he came back to his room."</p> <p>8. Interview on 3/26/26 at 9:07 a.m. with DON B revealed that she contacted the pharmacy regarding resident 44's Nitroglycerin Transdermal Patches. The pharmacy dispensed 60 patches; 20 doses of that medication (40 patches) were documented as</p>	F0760		

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F0760 SS = G	<p>Continued from page 81 administered, and 22 patches remained in the box. She expected there to be 20 patches remaining in the box.</p> <p>There was one dose (two patches) more than she expected. She felt that resident 44 had not received his 3/23/26 morning dose of that medication.</p> <p>RN F was suspended. DON B submitted a report to the South Dakota Department of Health and contacted resident 44's physician. On 3/25/26 at 4:48 p.m., she implemented monitoring of resident 44's pulse, blood pressure, and reports of chest pain or dizziness to occur for three days. Resident 44 was his own responsible person.</p> <p>DON B conducted interviews with resident 44, RN F, and LPN G.</p> <p>DON B reported that resident 44 told her that he felt anxious about not receiving his medication, but that resident 44 had not reported any dizziness or chest pain.</p> <p>9. Interview on 3/30/26 at 4:00 p.m. with pharmacist II revealed she was notified of a possible medication error involving resident 44 not receiving a dose of his Nitroglycerin Transdermal Patches.</p> <p>She felt that DON B put in place appropriate monitoring of resident 44 once she became aware of the possible medication error, and pharmacist II was told that resident 44 did not experience any adverse effects, and because of that, she would not have considered this medication being missed a significant medication error.</p> <p>She declined to list the potential adverse effects of resident 44 missing a dose of his physician-ordered Nitroglycerin Transdermal Patches. She stated that the facility identified what monitoring was needed and that monitoring had been put in place.</p> <p>10. Interview on 3/31/26 at 8:04 a.m. with LPN G revealed that on the evening of 3/23/26, when she went to remove resident 44's Nitroglycerin Transdermal Patches, there were no patches on his chest to remove, and she documented that.</p> <p>She did not inquire why those patches had not been put on or report that there were no patches to remove from resident 44's chest to her supervisor because she thought there must have been a valid reason resident 44 had not had them put on.</p>	F0760		

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F0760 SS = G	Continued from page 82 Resident 44 stated that the morning nurse did not put his patches on, but she was unsure if resident 44 said why the patches were not put on. She stated that she was very busy that night, and after she documented that there were no patches to remove, she did not think about it again. Her only interactions that night with resident 44 were when she provided him with his medications. She did not recall if resident 44 was upset about not receiving his medication as ordered. 11. Review of the provider's undated Medication Administration – General Guidelines policy revealed "Medications are administered as prescribed in accordance with good nursing principles and practices..." Review of the provider's reviewed 5/14/25 Medication Errors policy revealed "Errors will be documented, investigated, reported, and reviewed for need of intervention and to prevent recurrence."	F0760		
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F0812	1. Prior meal service observations could not be corrected. DA EE educated on safe food handling, hand hygiene, and resident eating assistance on 03/24/26. 2. All residents are at risk for deficient practice. Dining service observations were completed on 04/24/26 across all shifts with no identified areas of concern. 3. Root Cause Analysis: The facility lacked consistent monitoring and accountability of staff in safe food handling, resident eating assistance and hand hygiene practices. Administrator or designee will educate all staff on safe food handling, resident eating assistance, and hand hygiene by 05/08/26. Those not in attendance at education sessions will be educated prior to their next shift worked. 4. Administrator or designee will audit 5 random meal services to ensure safe food handling, resident eating assistance and hand hygiene weekly x6 weeks, monthly x2 months. Administrator or Designee will present audit findings monthly in QAPI meeting for progress review and recommendations.	05/08/2026

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F0812 SS = D	<p>Continued from page 83</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and policy review, the provider failed to follow standard food safety practices to ensure one of one observed dietary aide (DA) (EE) washed her hands after touching her face, hair, and pants, washed her hands for the required amount of time, wore gloves before handling resident's food, and replaced a milk jug lid after it fell on the floor in one of three dining rooms (Central).</p> <p>Findings include:</p> <p>1. Observation on 3/24/26 in the Central dining room revealed that at 11:34 a.m., DA EE touched her face, did not wash her hands, and placed covers on plates for the room trays. She touched her face again, did not wash her hands, and put the trays on the room tray cart.</p> <p>At 11:48 a.m., DA EE touched a resident's shoulder, took that resident's coffee cup into the kitchen, came out of the kitchen, and gave it back to her. She touched her face, did not wash her hands, obtained a plate of food for another resident, and served that to a resident. She touched her hair, obtained a plate of food, and served it to another resident.</p> <p>At 11:53 a.m., DA EE went into the kitchen and obtained butter. She did not wash her hands and used her bare hands to touch a resident's bread to apply the butter.</p> <p>At 11:59 a.m., DA EE dropped a chocolate milk lid on the floor in the dining room, picked it up off the floor, and put it back on the chocolate milk container.</p> <p>At 12:06 p.m., DA EE washed her hands in the sink for approximately four seconds, wiped her hands on paper towels, then wiped her left hand on the back of her pants, obtained a plate of food, and served it to a resident.</p> <p>2. Interview on 3/24/26 at 1:42 p.m. with DA EE revealed she was to sanitize her hands after every three resident plates were served and before putting the room trays on the cart.</p>	F0812		

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F0812 SS = D	Continued from page 84 She was supposed to sanitize her hands after touching a resident, her face, her hair, and her pants before serving resident plates. She was supposed to wash her hands and put on gloves before she touched the resident's food. When washing her hands in the sink, she was supposed to wash them for approximately 20 seconds. She did not recall dropping the chocolate milk lid on the floor and putting it back on the chocolate milk container. The milk lid should have been thrown away if it had been dropped on the floor. 3. Interview on 3/30/26 at 4:07 p.m. with dietary manager (DM) FF revealed that DAs are to sanitize their hands after every three resident plates are served, before putting room trays on the room tray cart, after touching their face or pants, and after touching residents. If the milk lid fell on the floor, it was to be thrown away. 4. Review of the provider's 5/15/25 Hand Hygiene policy revealed that the "facility considers hand hygiene the primary means to prevent the spread of infections." When washing their hands with soap and water, staff are to wash their hands for at least twenty (20) seconds. They are to wash their hands before and after handling food, and before and after direct contact with residents.	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F0880	1. Identified housekeeping concerns could not be corrected for previous observations. Housekeeper HH and Housekeeper DD were educated on hand hygiene, glove use and chemical contact times on 04/23/26. 2. All residents are at risk for deficient practice. Infection control practices regarding hand hygiene, glove utilization and chemical contact times for resident room cleaning was observed 04/23/25 with no identified concerns. Root Cause Analysis: The facility staff lacked understanding of facility infection control	05/08/2026

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(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
F0880 SS = D	<p>Continued from page 85 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p>	F0880	<p>practices related to hand hygiene, glove use, and chemical contact times related to language barriers. The facility lacked consistent monitoring for compliance of hand hygiene, glove use, and contact times. Administrator or designee will educate all staff on infection prevention practices including hand hygiene, glove use, and chemical contact times. Alternative education materials will be offered to staff with language barriers including translator/translated materials, 1:1 demonstration, peer-to-peer assistance. All staff will receive competencies on hand hygiene, glove use and chemical contact times. Education will be completed by 05/08/2026. Those not in attendance at education sessions will be educated prior to their next shift worked.</p> <p>4. Administrator or Designee will audit housekeeping infection control practices including hand hygiene, glove use, and chemical contact times 10 times a week x 6 weeks then monthly x 2 months. Administrator or Designee will present audit findings monthly in QAPI meeting for progress review and recommendations.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/31/2026
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F0880 SS = D	<p>Continued from page 86</p> <p>§483.80(e) Linens.</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and policy review, the provider failed to ensure the staff followed standard infection control practices regarding:</p> <p>*Hand hygiene (handwashing or hand sanitizer use) and glove use by two of two housekeepers (DD and HH) while cleaning residents' rooms.</p> <p>*Manufacturer's recommended chemical contact time (the duration a disinfectant must remain visibly wet on a surface to effectively kill pathogens) was followed by two of two housekeepers (DD and HH) while cleaning residents' rooms.</p> <p>Findings include:</p> <p>1. Observation on 3/24/26 at 2:29 p.m. of housekeeper HH cleaning room 221 revealed she put on a pair of gloves without performing hand hygiene. She entered room 221 and removed the garbage bags from the garbage cans on both sides of the room. The garbage bags were brought into the hallway and put in the garbage container on her housekeeping cart. Without removing her gloves or performing hand hygiene housekeeper HH took two clean garbage bags off a roll on her housekeeping cart, returned into room 221 and replaced the garbage bags on both sides of the room.</p> <p>Housekeeper HH exited room 221 with the same gloves on, did not remove the gloves or perform hand hygiene, and removed a bottle of Multi-Surface Peroxide cleaner and a cloth from her cart and brought them into room 221. She sprayed the countertop beside the sink and immediately wiped it off with the cloth. She then exited the room, entered the hallway, and placed the cloth and Multi-Surface Peroxide cleaner in her housekeeping cart. She did not remove her gloves or perform hand hygiene.</p>	F0880		

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NAME OF PROVIDER OR SUPPLIER AVANTARA NORTON			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE , SIOUX FALLS, South Dakota, 57105	
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F0880 SS = D	<p>Continued from page 87</p> <p>Housekeeper HH then entered room 221 with another cleanser and cloth and washed dried mud off the floor beside the resident's bed that was closest to the door. She exited the room and returned to her housekeeping cart in the hallway with the same gloves on, did not remove her gloves, or perform hand hygiene.</p> <p>She took the broom into room 221, swept the floor of the entire room and used the dustpan to pick up the dirt. She exited the room with her gloves on, with the broom and dustpan, and dumped the dirt in the garbage on her housekeeping cart. She did not remove her gloves or perform hand hygiene.</p> <p>Housekeeper HH then removed the mop pad from cleaning solution on her cart with the same gloves on, took it into room 221 and mopped the room. Once she had completed mopping, she exited the room with her gloves on. At her housekeeping cart she removed her gloves and used alcohol-based hand sanitizer to perform hand hygiene and applied a new pair of gloves.</p> <p>2. Observation and interview on 3/30/26 at 1:08 p.m. of housekeeper DD while she cleaned resident room 114 revealed she put on a pair of gloves without performing hand hygiene, sprayed the Multi-Surface Peroxide cleaner on the recliner and wiped it off with a cloth. She then sprayed the cabinet with the Multi-Surface Peroxide cleaner and wiped it off with a cloth.</p> <p>Housekeeper DD sprayed the bed with the Multi-Surface Peroxide cleaner and wiped it off with a cloth. Housekeeper DD then exited the resident room, removed her gloves and performed hand hygiene.</p> <p>Housekeeper DD stated she used the Multi-Surface Peroxide cleaner when she cleaned hard surfaces in residents' rooms. She stated she would let the Multi-Surface Peroxide cleaner remain on a surface if it was visibly soiled before she wiped it off. If the area was not visibly soiled, she sprayed the cleaner on and wiped it off immediately</p> <p>The label on the Multi-Surface Peroxide cleaner stated, "1. Spray on hard surfaces to be cleaned. 2. Wait: 1-2 [one to two] minutes. 3. Agitate (if necessary). 4. Wipe Dry."</p> <p>3. Interview on 3/31/26 at 12:22 p.m. with housekeeper EEE revealed she used the Multi-Surface Peroxide cleaner on surfaces in the residents' room such as their over-the-bed table and countertop beside the</p>	F0880		

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F0880 SS = D	<p>Continued from page 88 sink.</p> <p>She did not know if the Multi-Surface Peroxide cleaner had a contact time for disinfection. She stated she would have to "read up on that."</p> <p>4. Director of housekeeping DDD was not in the facility or available for interview during the second week of the survey.</p> <p>5. Interview on 3/31/26 at 12:40 p.m. with licensed practical nurse (LPN)/unit manager/infection preventionist C and wound care certified, regional nurse consultant (RNC) L revealed LPN/unit manager/infection preventionist C expected staff to perform hand hygiene before they applied gloves and after they removed their gloves, before entering a resident's room, and after leaving a resident's room.</p> <p>Gloves were to be changed between residents, when a dirty task was completed and before a clean task was started.</p> <p>LPN/unit manager/infection preventionist C stated she would expect staff to follow the identified contact time needed for each chemical to disinfect the surface it was applied to.</p> <p>Wound care certified, regional nurse consultant L advised LPN/unit manager/infection preventionist to answer no further questions related to housekeeping glove use and hand hygiene or chemical contact times because she could not speak for housekeeping's infection control practices.</p> <p>6. Interview on 3/31/26 at 1:41 p.m. with administrator A revealed hand hygiene and glove use was standard between all departments within the facility unless there was something specific identified in the policy.</p> <p>She expected all staff to follow the recommended contact time for each chemical they used to clean resident care items and surfaces.</p> <p>7. Review of the provider's 5/15/26 Hand Hygiene policy revealed "All personnel shall follow the hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors."</p> <p>"If hands are not visibly soiled, use an ABHR [alcohol</p>	F0880		

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F0880 SS = D	Continued from page 89 based hand rub] ...for all the following situations:Before and after direct contact with residentsWhen entering and leaving a Resident care area/roomBefore donning [putting on] and after removing gloves". "The use of gloves does not replace hand hygiene. Hand hygiene must be completed prior to and after [the] removal of gloves."	F0880		

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E0000	Initial Comments 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 3/24/26. Avantara Norton was found in compliance.	E0000		

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 Ashley Nickel	TITLE Administrator	(X6) DATE 05/01/2026
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026
NAME OF PROVIDER OR SUPPLIER AVANTARA NORTON			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE , SIOUX FALLS, South Dakota, 57105	
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K0000	INITIAL COMMENTS A recertification survey was conducted on 3/24/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Norton was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K223, K321, and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0223 SS = D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to ensure two randomly observed corridor doors (From the clean linen and timeclock rooms) were equipped with functioning positive latching hardware.	K0223	1. Door from clean linen room closure repaired 03/25/26. 2. All residents are at risk for deficient practice. All door closures assessed for proper function by 05/08/2026. Any doors identified to need repair will be entered into work orders for repair. 3. Root Cause Analysis: Door closure in disrepair, lack of door monitoring to ensure closures are in good working order. Administrator or designee will educate all staff on importance of entering work orders to ensure prompt repair by 05/08/2026. Those not in attendance of all staff will be educated prior to next shift. 4. Administrator or designee will audit 5 door closures weekly to ensure proper function x 6 weeks then x2 months. Administrator or Designee will present audit findings to QAPI meeting monthly to review progress and recommendations.	05/08/2026

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 Ashley Nickel	TITLE Administrator	(X6) DATE 05/01/2026
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026	
NAME OF PROVIDER OR SUPPLIER AVANTARA NORTON		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE , SIOUX FALLS, South Dakota, 57105		
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K0223 SS = D	<p>Continued from page 1</p> <p>Findings include:</p> <p>1. Observation and testing on 3/24/26 at 11:40 a.m. of the door from the clean linen room into the corridor revealed that door was equipped with a closer, but it was not automatically latching into the door frame. That door hit its frame upon closing and was kept from fully latching into the frame.</p> <p>2. Observation and testing on 3/24/26 at 11:41 a.m. revealed the corridor door from the time clock room was equipped with a closer, but it was not automatically latching into the door frame. That door hit its frame at the top corner upon closing and kept it from latching.</p> <p>Doors provided with closers are required to latch into their frames automatically.</p> <p>Interview with the maintenance director at the time of the observation and testing confirmed those findings. He stated he was unaware of those conditions. He further stated the top hinges of each of those doors had become loose since he had last checked them. He went on to say he believed that was causing them not to latch into their respective frames. Those Doors were adjusted and were operating properly before the end of the survey that day.</p>	K0223		
K0321 SS = D	<p>Hazardous Areas - Enclosure</p> <p>CFR(s): NFPA 101</p> <p>Hazardous Areas - Enclosure</p> <p>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.</p> <p>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</p>	K0321	<p>1. Central supply room was cleared of combustibile items on 03/25/26. The corridor door to central supply room removed and staff putting away central supply educated. Door Closure placed on the central supply room 03/25/26.</p> <p>2. All residents are at risk related to deficient practice.</p> <p>3. Root Cause Analysis: Door did not have a closure attached to the door and lack of education and staff understanding of safety risks of propping a door or utilizing a rope to hold door open. Administrator or Designee will educate all staff with access to central supply closet on door closures and that doors should not be propped open or tied open. Those not in attendance of all staff will be educated prior to next shift.</p>	05/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026
NAME OF PROVIDER OR SUPPLIER AVANTARA NORTON			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE , SIOUX FALLS, South Dakota, 57105	
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K0321 SS = D	Continued from page 2 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain one randomly observed hazardous area (east central supply room) as required. Findings include: 1. Observation on 3/24/26 at 4:21 p.m. revealed the east central supply room was over 100 square feet and contained combustible items. The corridor door to that room was held open by a small rope tied to shelving and would not close and latch with the operation of the closer. Interview with the maintenance director at the time of the observation confirmed that finding. He stated the staff person who was there loading items had tied that door open for their convivence, and he was aware that corridor door was not allowed to be tied open.	K0321	4. Administrator or Designee will complete audits of door closure utilization and/or staff not propping doors open or tying doors open with rope will be completed weekly x 6 weeks, monthly x2 months. Administrator or Designee will present audit findings to QAPI meeting monthly to review progress and recommendations.	
K0712 SS = D Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills	K0712	1. The facility unable to correct observations of deficient practice. 2. All residents are at risk related to deficient practice.	

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K0712 SS = D Bldg. 01	<p>Continued from page 3 Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>19.7.1.4 through 19.7.1.7</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, the provider failed to ensure corridors and exit routes were kept clear of any obstructions to ensure smooth and rapid evacuation during a fire drill or emergency. (in the 300 wing).</p> <p>Findings include:</p> <p>1. Observation on 3/24/26 at 10:40 a.m. revealed the fire alarm was sounded to initiate a drill via simulated smoke being spread into the smoke detector for a simulated fire in resident room 301. The staff responding to the simulated fire location did not clear the corridor of obstructions to ensure smooth and rapid evacuation. A Tenor lift remained in the corridor directly west of the door to room 301.</p> <p>Interview with the maintenance director at the time of the observation confirmed that finding.</p> <p>The deficiency had the potential to affect 100% of the occupants of that smoke compartment.</p>	K0712	<p>3. Root Cause Analysis: Lack of all staff education and understanding fire policy expectations and RACE (Rescue, Alarm, Contain, Extinguish/evacuate). Administrator or designee will complete education with all staff on Fire Drill policy and RACE by 05/08/2026. Those not in attendance of all staff will be educated prior to next shift.</p> <p>4. Administrator or designee will complete weekly Fire Drill. Administrator or Designee will audit Fire Drills weekly x 6 weeks then monthly x 2 months. Administrator or Designee will present audit findings to QAPI meeting monthly to review progress and recommendations.</p>	05/08/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10682	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/31/2026
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NAME OF PROVIDER OR SUPPLIER AVANTARA NORTON	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S NORTON AVENUE SIOUX FALLS, SD 57105
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(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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/24/26 through 3/26/26 and from 3/30/26 through 3/31/26. Avantara Norton was found not in compliance with the following requirements: S323.	S 000		
S 323	44:73:08:06(1-4) Documentation of Medication Disposal A facility shall ensure that a legend medication not controlled under SDCL chapter 34-20B is destroyed or disposed of by a nurse and another witness. Destruction or disposal of medication controlled under SDCL chapter 34-20B must be witnessed by two persons, both of whom must be a nurse or pharmacist, as designated by facility policy. The following are authorized methods of destruction or disposal: (1) Using a professional waste hauler to take the medications to a permitted medical waste facility or by facility disposal at a permitted municipal solid waste landfill. Prior to disposal all medications must be removed from original containers and made unpalatable by the addition of adulterants and alteration of solid dosage forms by dissolving or combination into a solid mass; (2) Return to the dispensing pharmacy for destruction according to federal and state regulations; (3) Return to an authorized reverse distributor company licensed by the South Dakota Board of Pharmacy; or (4) Release to resident upon discharge after authorization by the resident's prescribing practitioner.	S 323	1. The facility is unable to correct the prior destruction of controlled medications. 2. CMA/CNA BB and LPN X were educated on destruction of controlled medications by two nurses, and that a CMA is not authorized to destroy medications on 03/31/2026. 3. Root Cause Analysis: The facility staff lacked understanding of job scope related to medication destruction protocols and lacked understanding that destruction of controlled medications is required to be completed by two nurses or pharmacists. All staff who are authorized to pass medications will be educated on controlled medications must be disposed of by two authorized staff both of whom must be a nurse or a pharmacist. Those not in attendance at education sessions will be educated prior to their next shift worked. DON or Designee will audit controlled medication destruction to ensure that is completed by two authorized staff, both of whom are a nurse or a pharmacist weekly x 6 weeks then monthly x 2 months. DON or Designee will present audit findings monthly in QAPI meeting for progress review and recommendations	05/08/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Ashley Nickel

TITLE

Administrator

(X6) DATE

05/01/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10682	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/31/2026
NAME OF PROVIDER OR SUPPLIER AVANTARA NORTON		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S NORTON AVENUE SIOUX FALLS, SD 57105		
(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) COMPLETE DATE
S 323	<p>Continued From page 1</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure controlled medications (medications with risk for abuse, addiction, and potential theft) were destroyed by two authorized staff members, who were a nurse or pharmacist.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Observation on 3/25/26 at 12:52 p.m. of certified nursing assistant (CNA)/certified medication aide (CMA) BB preparing to administer Tramadol 50 milligrams (mg) (a scheduled IV controlled substance to treat pain) for resident 61 revealed she dropped the medication on the floor. She notified licensed practical nurse (LPN) X. CNA/CMA BB and LPN X destroyed the Tramadol 50 mg tablet by placing it in a controlled medication container that deactivated the medication. They both signed the Tramadol controlled medication sheet that the pill was destroyed by them. 2. Interview on 3/31/26 at 10:17 a.m. with registered nurse (RN) T revealed that CMAs could not destroy controlled medications, and it had to be done with another nurse. 3. Interview on 3/31/26 at 10:25 a.m. with RN unit manager J revealed that CMAs could not destroy controlled medications. 4. Interview on 3/31/26 at 11:07 a.m. with CNA/CMA BB revealed she was told she could destroy controlled medications with a nurse since she was able to administer them. 5. Interview on 3/31/26 at 1:05 p.m. with director 	S 323		

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S 323	<p>Continued From page 2</p> <p>of nursing (DON) B revealed that CMAs could not destroy controlled medications, and the Tramadol tablet should have been destroyed by two nurses.</p> <p>6. Review of resident 61's electronic medical record (EMR) revealed he had an 11/21/25 physician's order for Tramadol 50 mg to be given three times a day and a 2/26/26 physician's order for Tramadol 25 mg to be given every eight hours as needed for pain.</p> <p>7. Review of the provider's 11/18/25 Drug Diversion Prevention policy revealed that the facility was to "set forth standards related to preventing the diversion of medications. Medications classified by the Drug Enforcement Administration (DEA) as controlled substances are subject to special handling, storage, disposal, and record keeping" "Controlled substances will be destroyed following state specific regulations and following policies and procedures manual of providing pharmacies."</p> <p>8. Review of the provider's undated Controlled Substance Disposal policy revealed that controlled medications were to be destroyed in the presence of two licensed nurses, and the disposal was to be documented on the accountability record/book on the line representing that dose.</p>	S 323		