STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435068	A. BUILDING B. WING	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA WATERTOWN	415 FOURTH AVE NE , WATERTOWN, South Dakota, 57201

(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 An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/21/26 through 4/23/26 and 4/27/26 through 4/29/26. Avantara Watertown was found not in compliance with the following requirements: F552, F554, F583, F585, F605, F609, F628, F641, F644, F655, F657, F658, F695, F700, F759, F760, F761, F806, F835, F837, and F865, with Immediate Jeopardy violations at F600 and F689. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/21/26 through 4/23/26 and 4/27/26 through 4/29/26. The areas surveyed were dietary services regarding the quality of the food, quality of care/treatment of residents regarding an elopement, falls, wound care, missing fentanyl patches, resident safety, infection control, and allegations of resident abuse/neglect regarding unsafe resident transfers. Avantara Watertown was found not in compliance with the following requirements: F550, F609, F655, F657, and F835.	F0000		
F0689 SS = SQC-K	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: A. Based on observation, interview, record review, and policy review, the provider failed to ensure	F0689	1. Residents #23, #35, and #48 identified rails have been assessed and tightened. All residents with bed rails to have new UDA/assessment completed on 4/22/2026 to ensure they need the side rails, they can safely use the side rails, and side rails zone measurements with the mattresses are within the requirements. All residents with bed rails are at risk for deficient practice. Maintenance completed a 100% audit of all beds with side rails, grab bars, or mobility devices was completed on 4/23/26. Audits included: verification of secure side rail/mobility bar installation, measurement of all applicable entrapment zones, inspection of mattress fit and stabilization, verification that mattress stabilizers and hardware were present and intact. All residents with mobility bars were screened	6/2/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lynna M. Speier	LNHA	6/2/2026

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F0689 SS = SQC-K	Continued from page 1 resident safety regarding the side rails/grab bars and mattresses on the resident's beds were assessed for entrapment (trapped between the rail, mattress, or bedframe spaces) risk for three of three sampled residents (23, 35, and 48) who had loose side rails/grab bars on their beds and three of three sampled residents (23, 32, and 35) who had an unsecured mattress on their bed. Those failures put the identified residents at risk for entrapment injury or harm. Findings include: 1. Observation and interview on 4/22/26 at 10:31 a.m. with resident 35 in his room revealed his bilateral side rails could move away from his bed one to two inches. He stated they had been like that since he admitted to the facility. 2. Observation on 4/22/26 at 3:27 p.m. of resident 35's bed revealed there was a gap of five inches between the top of his mattress and the headboard. The top opening of his bilateral side rails measured four and three-quarter inches in width by five and one-half inches in height. The bottom opening measured four and three-quarters inches in width by four and one-half inches in height. 3. Observation and interview on 4/22/26 at 10:16 a.m. with resident 48 in his room revealed he had bilateral side rails on his bed. He used the left side rail to get in and out of bed, but it was loose. He did not use the right-side rail because it was against the wall. He thought the side rails were on his bed because he had nightmares which made him move around in bed and he had fallen out of his bed due to the nightmares. His left side rail could move away from the mattress three inches when pulled. He denied that he had gotten a body part stuck in the either side rail. He had told a certified nursing assistant (CNA) and his daughter that his left side rail was loose but did not know when he told them. He thought it was a week or so. 4. Review of resident 48's electronic medical record (EMR) revealed he was admitted to the facility on 4/26/22. He had a 3/13/26 Brief Interview of Mental Status (BIMS) assessment score of 15, which indicated his cognition was intact. His diagnoses included that he was legally blind. On 8/15/25 resident 48 had a dream and fell out of his bed. He was sent to the emergency room after this fall and	F0689	by therapy by 4/24/26 to confirm continued appropriateness, determine whether alternative interventions would be more appropriate, or identify if the mobility bar was no longer needed. IDT completed a review of physician orders, consents, and assessments related to side rail use. Any identified concerns were corrected immediately through repair, replacement with new model of mobility bar throughout the facility, removal, or adjustment of equipment. 2. System was reinforce for the bed rail/ entrapment assessment process to ensure all applicable entrapment zones are assessed upon installation, monthly, with mattress changes, and with changes in condition. On 4/23/26, all staff minus dietary were re-educated by the Regional Nurse Consultant regarding FDA entrapment guidance, proper installation and tightening of side rails and mobility bars, accurate entrapment zone measurements, mattress stabilization requirements, documentation expectations, immediate reporting and correction of unsafe gaps or loose equipment, side rail consents, physician orders, and assessments were reviewed for accuracy and completeness. Nursing staff were educated on requirement to attempt and document alternative interventions prior to recommending a mobility aid to PCP. Maintenance audit tools were revised to clearly identify all applicable entrapment zones and prohibit use of "not applicable" unless clinically appropriate. The Administrator, DON, and interdisciplinary team, in collaboration with the medical director, reviewed policies and procedures that address resident safety, including but not limited to measures to ensure safe mattress and bed mobility bars, such as assessing and identifying safety risks, ongoing monitoring of equipment and resident ability to use equipment safely, and maintaining the residents' equipment and environmental risk/hazards in safe working conditions. Those policies and procedures specifically include all aspects to ensure the safe use of mattresses and bed mobility bars. Education and training was completed with all facility staff about their roles, responsibilities,	

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F0689 SS = SQC-K	Continued from page 2 was diagnosed with a brain bleed. 5. Observation and interview on 4/22/26 at 10:36 a.m. with resident 23 in her room revealed she used the bilateral side rails to roll over in bed. The right-side rail could move away from the bed two to three inches when pulled. Resident 23 did not know how long her side rail had been loose. The opening within the bilateral side rails measured three and one-half inches wide by 13 inches in height. The space between the foot of her mattress and the footboard was seven inches. 6. Observation and interview on 4/22/26 at 6:25 p.m. with licensed practical nurse (LPN) N in resident 32's room revealed resident 32 had a side rail on the right side of her bed. LPN N determined if a side rail or mattress was a risk for entrapment for a resident if there was a gap that a body part could be trapped in. LPN N measured the space at the top of the mattress to the side rail and the bottom of the mattress to the side rail when she assessed for an entrapment. She centered the mattress on the bed when she took the measurement even if the mattress could be slid over. Resident 32's mattress was able to slide to the wall leaving an eight-inch gap between the mattress and the side rail. 7. Review of the maintenance logbook for side rail inspections for January 2026 through April 2026 revealed that in January the side rail audits indicated that zone 1 (the opening within the side rail) was the only entrapment zone assessed. The other six zones of entrapment were documented as "not applicable". In February all seven zones of entrapment were documented as having "passed" the audit on every bed assessed. In March only zone 1 was documented as being assessed, all the other six zones were documented as "not applicable". In April six side rail assessments were documented as "passed" for zone one with "not applicable" for the other 6 zones. Twenty-one side rail audits were documented as "not applicable" for all seven zones. Those residents documented as not applicable for all seven entrapment zones in April 2026 included residents 2, 3, 4, 12, 14, 16, 17, 22, 23, 31, 33, 35, 36, 37, 45, 47, and 48. Residents who were identified as having side rails that were not included on the April 2026 side rail audit included residents 8, 27, and 32. There were no entrapment assessments for zone 7 (the space between a mattress and headboard or	F0689	and assigned tasks regarding all aspects of resident safety, the residents' safe use of equipment, and maintaining a hazard-free resident environment. Competencies of staff knowledge within 30 days upon hire, annually and as needed. 3. Administrator/designee will audit 5 residents with mobility bars weekly for 4 weeks to ensure: the device is being used for its intended purpose; a current physician order is present; resident/ responsible party consent forms are fully completed and signed; UDA documentation in PCC is completed per schedule; the care plan includes the device and clinical rationale for use; and required gap measurements/entrapment zone assessments are completed per facility schedule, then monthly for two additional months. Administrator or designee will present audit findings monthly in QAPI meeting for progress review and further recommendations.	

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F0689 SS = SQC-K	Continued from page 3 footboard) from January 2026 through April 2026 documented for residents without a bed rail. 8. Interview on 4/22/26 at 6:06 p.m. with director of nursing (DON) B revealed she was unsure if the provider had a policy related to entrapment assessments. She thought maintenance did the entrapment assessments on the residents' beds. The side rail assessments were to be completed by the nurse on the resident's admission if the resident or the resident's representative wanted a side rail and quarterly by the Minimum Data Set (MDS) nurse. DON B completed the consent for side rails with the resident or the resident representative and that consent had the risks versus benefits of having a side rail on it. 9. Notice of immediate jeopardy (IJ) of F689 was given verbally and in writing on 4/22/26 at 7:00 p.m. to administrator A regarding the resident's side rails not being securely attached and the mattresses on residents' beds not being assessed for entrapment. Observations made throughout the survey and throughout the entire building on 4/22/26 revealed there were several safety concerns related to side rail installation, maintenance, and bed zone assessments. Residents 23, 35, and 48 had side rails that were not securely attached to their bed, which created a risk for resident entrapment and injury. Resident 23's side rail openings measured three and one-quarter inches in width by 13 inches in height, was loose and separated from the mattress with over two inches of a gap which created a risk for entrapment and injury. Resident 48's side rail opening measured three and one-quarter inches in width by 11 inches in height, was loose, and separated from the mattress with over two inches of a gap which created a risk for entrapment and injury. Resident 35 had a five-inch gap between the top of his mattress and his headboard which created a risk for entrapment and injury. The above concerns had the potential to cause serious harm, injury, impairment, or death for residents. A plan for removal of the immediacy was requested at that time. 10. On 4/23/26 at 10:14 a.m. the provider submitted the following IJ removal plan for review,	F0689		

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F0689 SS = SQC-K	Continued from page 4 Residents #23, #35, and #48 with identified safety concerns related to bed rail installations, maintenance, and bed zone assessments were addressed immediately. Bed rails for these residents were inspected and tightened to ensure secure installation. In addition, a 100% audit of all beds in the facility was completed on 4/23/2026 to specifically address gaps between side rails and mattresses and to confirm overall bed system safety. All residents with side rails or mobility bars had assessments and entrapment zone measurements completed to ensure compliance with regulatory requirements. During this process, mattress stabilizers were identified as removed from select beds, which contributed to potential gaps; these were corrected immediately by reinstalling hardware, adjusting components, or replacing beds as needed. All mattresses were evaluated to ensure proper fit with no gaps at the head, foot, or sides of the bed. At the conclusion of the audit, no residents were identified as having unsafe bed systems. The Regional Nurse Consultant provided education to Maintenance and Nursing staff on proper installation, inspection, and entrapment zone measurement requirements for bed rails, mobility bars, and mattresses. Education included all entrapment zones and emphasized the importance of completing measurements from a stabilized mattress position, including assessing for potential mattress shift during use to ensure accuracy. All staff were educated to immediately report any identified gaps between the mattress and bed frame or any loose mobility bars/side rails to the Maintenance Department for prompt correction. Nursing and Maintenance staff were additionally educated on the audit process and expectations for ongoing monitoring, including accurate completion of entrapment zone measurements. Education was conducted at the start of shift, and all staff present completed training, with plans in place to educate any staff not in attendance. The Maintenance Director or designee will conduct ongoing audits of 4 random residents with mobility bars/rails weekly for 4 weeks, followed by monthly audits for 2 additional months, including verification that all side rails and mobility bars are secure, all entrapment zone measurements meet regulatory requirements, and all mattresses fit appropriately without gaps and remain stabilized. Audits will also include confirmation that mattress stabilizers and related hardware remain in place. Results of these audits will be reviewed by the Administrator, Director of Nursing, or designee in collaboration with the	F0689		

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F0689 SS = SQC-K	Continued from page 5 Interdisciplinary Team (IDT) and Medical Director at monthly Quality Assurance Performance Improvement (QAPI) meetings. Findings will be analyzed for trends and used to determine the need for continuation, revision, or discontinuation of the audits based on findings. 11. The immediacy was removed on 4/23/26 at 3:40 p.m. after the survey team verified on site that the provider had implemented their removal plan through observation, document review, and staff interviews. After the removal of the IJ, the scope and severity of the noncompliance remained at an E. Current census was 45 residents. 12. Interview and review of the maintenance logbook for side rail inspections on 4/28/26 at 10:15 a.m. with regional maintenance II revealed when the maintenance staff completed the side rail audits they would first verify with the nurses that the residents still needed the side rail on their bed, and if they had left, right, or bilateral side rails. The maintenance staff would check the side rail to ensure it was tightly secured to the resident's bed and measured the entrapment zones to ensure they were less than four and three-quarter inches. He expected all seven entrapment zones to be checked but with the style of side rail that was in the facility only three of the zones applied. The side rail audits were to be completed by maintenance monthly. During the side rail audits the mattress was to be measured to be sure there was not a large gap between the mattress and the footboard or headboard. The measurements of the gaps between the mattress and head and footboard as well as the side rails were completed with a tape measure. He was not aware that in March 2026, only entrapment zone one was audited, and all the other zones were documented as "not applicable" or that in April 2026 the side rail audit indicated all seven zones were "not applicable". He expected all entrapment zones to be checked monthly and documented as "passed" or "not applicable". When the open area within the side rail was measured, the maintenance staff only measured one direction because the height of the upside-down U-shaped side rails was about 11 inches in height. He acknowledged that there were gaps between some residents' mattresses and their head or	F0689		

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F0689 SS = SQC-K	Continued from page 6 footboard which posed a risk for entrapment and there were loose side rails on the residents' beds which posed a risk for injury. 13. Interview on 4/29/26 at 9:30 a.m. with administrator A revealed that the maintenance staff was responsible for completing monthly audits of the residents' side rails to be sure nothing had changed or was modified since their original installation. The audits of the side rails were documented in the facility's online maintenance system. Administrator A reviewed that system to be sure the side rail audits were completed. If a resident was identified as needing a side rail installed that recommendation was communicated to the family and the resident's physician. The risks and benefits of the side rail, including entrapment, were reviewed with the resident or the resident's family and representative, and once those steps were completed the maintenance department would install the side rail. The maintenance staff were to ensure the entrapment zone measurements were in compliance with the recommendations from the food and drug administration (FDA). She stated the measurements within the opening of the side rails were to be less than four and three-quarter inches in width, and the FDA guidance did not address the measurements related to the height of the opening within the side rails. 14. Interview on 4/29/26 at 10:09 a.m. with DON B revealed the consent for side rails was in the resident's admission packet and all residents were offered side rails at the time of their admission. DON B stated she knew that alternate interventions should be attempted before side rails were put on a resident's bed, but she was following the resident's and the resident representative's wishes. The physical and occupational therapy staff also recommended side rails for some residents who received therapy to improve their mobility and independence. DON B acknowledged that there was missing documentation related to the side rail assessments, consents, and physician orders. She stated there were side rails on the residents' beds that were not documented when they were put on. She acknowledged that there was a risk for resident entrapment and injury when entrapment zone measurements and assessments were not completed on the side rails and mattresses, and when the side	F0689		

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F0689 SS = SQC-K	Continued from page 7 rails were loose. 15. Review of the provider's 11/18/25 Bed Rail policy revealed, "These cbars [side rails] pose safety hazards and must be evaluated for appropriate placement for the sole purpose of transfer and bed mobility assistance for the resident." "The Entrapment Zone Review Form (or electrical format in TELS) is completed upon placement of rails, quarterly and with a resident change of condition. Entrapment zones should be assessed with any changes of mattress. B. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, record review, and policy review, the provider failed to ensure the safety of: *One of one sampled resident (58) who fell from his bed that was left in an elevated position by CNA Z and required further evaluation in the emergency department (ED) due to a possible head injury. *One of one sampled resident (22) who was assisted by CNA NN with a sit to stand (a mechanical lift used to assist from a seated to a standing position) lift transfer done incorrectly which caused the resident to have pain. *One of one sampled resident (56) identified as at risk for elopement (leaving the facility without staff knowledge) who eloped through an unsecured door and was outside for approximately 15 minutes. *One of one sampled resident (59) who fell while transferring herself to the bathroom and hit her head which required an ED evaluation, when the provider failed to implement review and revise interventions to reduce the risk of falls when she fell 11 times in 30 days. Findings include: 1. Review of the provider's 1/8/26 SD DOH FRI revealed on 1/8/26 at 11:15 p.m. resident 58 fell out of his bed. When the staff responded to resident 58 they noted that his bed was not in its lowest position. Registered nurse (RN) OO thought resident 58 hit his head during the fall and due to him being on an anticoagulant (blood thinning) medication he was transported by ambulance to the ED for evaluation. He returned to the facility from the ED	F0689	1. Residents #58's fall incident was investigated. Staff were re-educated regarding maintaining beds in the lowest position unless otherwise care planned. Resident #22's transfer care plan and lift requirements were reviewed and reinforced with staff. Contracted staff involved were removed from providing care pending competency review. Resident #56's elopement risk interventions were reviewed and revised, including implementation of wander guard monitoring and reinforcement of activated door alarms. Resident #59's falls were reviewed through interdisciplinary assessment. Fall interventions, supervision, toileting schedules, monitoring, and environmental safety measures were reassessed and updated. All residents are at risk for deficient practice. The facility completed audits of residents at risk for falls, requiring mechanical lift transfers, at risk for elopement and requiring specific bed positioning or supervision interventions. No additional concerns were identified. 2. On 6/1/2026, the DON or designee re-educated all nursing staff, CNAs, and contracted staff regarding following individualized care plans, requirement for two-person transfers when indicated, bed safety and lowest bed position expectations, elopement prevention procedures, fall prevention, root cause analysis, and intervention updates after each fall by DON or designee. Competencies of staff knowledge within 30 days upon hire, annually and as needed. The facility reinforced expectations that all direct care staff review updated care plans,	6/2/2026

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F0689 SS = SQC-K	Continued from page 8 after a few hours with a diagnosis of a minor closed head injury and abrasions to his left forearm, wrist, and knee. Resident 58 was trying to take off his socks while he was in bed and due to his left-sided weakness from a prior stroke (blood supply to the brain is blocked or reduced), he fell sideways and out of bed. Resident 58's bed was left in an elevated waist high position by CNA Z at 9:30 p.m. 2. Review of CNA Z's 1/9/26 fall witness statement revealed she had assisted resident 58 to bed at approximately 9:30 p.m. She did not have a pocket care plan (a document that identifies residents' care needs and interventions) to reference because "the system" was not working so she left his bed at waist height. 3. Review of resident 58's EMR revealed he was admitted to the facility on 12/31/25 and passed away on 2/4/26. His diagnoses included a stroke with left sided weakness or paralysis. His care plan (personalized plan that addresses a resident's care needs, goals, and interventions) did not identify a specific height at which his bed was to be positioned before he fell from his bed on 1/9/26. After he fell out of bed on 1/9/26 his care plan indicated he had a high risk for falling, and his bed was to be left in the lowest position for his safety. 4. Interview on 4/29/26 at 9:10 a.m. with CNA HH revealed that if a resident was not care planned for a specific bed height the resident's bed was to be positioned at a height that when that resident sat up on the side of the bed their feet would rest flat on the floor. 5. Interview on 4/29/26 at 10:09 a.m. with DON B revealed she was notified when resident 58 fell out of bed. When she completed her investigation, she found out he was trying to remove his socks while he was in bed and due to his left-sided weakness because of his stroke he fell to the side and out of bed. His bed was not in the lowest position after the staff had assisted him to bed. She expected the staff to leave the residents' beds in the lowest position after they had completed cares for that resident. 6. Review of the 2025 CNA competency checklist that was used upon hire and annually revealed that	F0689	pocket care plans, and communication binders each shift. Door alarm was replaced to ensure alarms remain activated unless residents are directly supervised exiting the building. Management reinforced supervisory expectations for charge nurses to monitor CNA compliance with resident care plans and transfer requirements. 3. DON/designee will audit 5 residents' care plans to identify risk and appropriate interventions are in place weekly for 4 weeks, then monthly for two additional months. Administrator or designee will present audit findings monthly in QAPI meeting for progress review and further recommendations.	

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F0689 SS = SQC-K	Continued from page 9 the bed mobility competency required the resident's bed to be left in the low position after the staff assisted the resident. 7. Review of the provider's 4/25/26 SD DOH FRI revealed that resident 22 had sustained a back injury when contracted travel CNA NN transferred him using a sit-to-stand lift with a sling that was too small. Contracted travel CNA NN transferred the resident without another staff member's assistance when resident 22's care plan indicated he required two staff members to assist him to transfer. Resident 22 needed further outside medical evaluation for the injury. His care plan was updated to reflect that he should no longer receive care from contracted travel staff, only the provider's staff. 8. Interview on 4/22/26 at 10:06 a.m. with resident 22's family member revealed that although his care plan indicated he needed two staff members to assist him with transfers, she said, "there's usually just one person transferring him." 9. Interview on 4/22/26 at 3:04 p.m. with social services designee (SSD) J revealed that updates to the resident's care plans were added to a communication book that the staff were to read each day before their next shift. 10. Interview on 4/27/26 at 2:16 p.m. with CNA U revealed that she determined how to transfer a resident by referencing the resident's care plan or Kardex (a report of the resident's care needs and interventions). 11. Interview on 4/27/26 at 3:53 p.m. with resident 22 revealed that he was aware that two staff members were supposed to help him transfer. He stated, "Just one person comes to get me for my bath. I'm supposed to have two people [transfer me] at all times." He stated that he thought the contracted travel staff were not always aware that he was to be transferred by two staff members. He informed DON B when only one staff member transferred him. 12. Interview on 4/28/26 at 11:35 a.m. with resident 22's family member revealed that on 4/24/26, she had to show a contracted travel CNA how to use a mechanical lift in resident 22's room. Resident 22's	F0689		

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F0689 SS = SQC-K	Continued from page 10 family member stated, "I asked her if she knew how to use the lift and she said, 'No, but I can look it up.' A nurse called [me] the next morning [to report the 4/25/26 incident], and she apologized and said a CNA transferred him [resident 22] by herself and he got hurt." 13. Interview on 4/28/26 at 12:15 p.m. with LPN KK revealed that as a contracted travel nurse, she was expected to arrive early on her first day at a facility to complete training on how to operate the mechanical lift equipment. She said the training only occurred the first time she was hired for a provider, and that the same models of lifts were used at most locations, "so once you get the training, you don't need it again." She stated that she referenced the residents' care plan and Kardex to determine their required transfer assistance. 14. Interview on 4/28/26 at 2:09 p.m. with MDS RN H revealed that when resident care plans were updated, there was a binder at the nurse's station with updates of resident care needs and the staff were to review and sign the sheet to indicate that they were aware of the changes. She stated that the residents' transfer assistance needs were also documented on the resident Kardex and on report sheets that the CNAs referenced during each shift. The residents' care plans were reviewed and updated at least quarterly. She expected the care plans to be accurate and to reflect the residents' current needs. 15. Interview on 4/28/26 at 3:15 p.m. with DON B, regional nurse consultant (RNC) C, and administrator A revealed that the provider's staff completed regular competency assessments for using the lifts, and the contracted staff's employment agencies were expected to complete those evaluations with their contracted travel staff. DON B stated that the provider's CNAs were to reference a binder at the nurse's station that contained the manufacturer's instructions for each lift model to train the travel staff on how to operate the lifts. She indicated that resident 22 "is competent enough that he'll tell me if only one person transferred him," and that the staff informed her when they saw others perform transfers incorrectly. If a resident's transfer status or care plan changed, DON B would print education for the staff, and the night shift [staff] would pass it on.	F0689		

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F0689 SS = SQC-K	Continued from page 11 16. Interview on 4/29/26 at 8:19 a.m. with DON B revealed that the residents were evaluated by the therapy staff to determine the level of assistance they needed to transfer. She stated that CNAs have also recommended transfer assistance by two staff members for residents whose needs increased. Residents who used a full-body lift (a mechanical lift and sling used to lift a person's full body) were always to be transferred with the lift operated by two staff members. 17. Interview on 4/29/26 at 9:30 a.m. with administrator A revealed that she expected managers to communicate resident care plan updates to the staff. She indicated that there was a disconnect in communication due to having several new staff members. She stated that the resident's care plan was a living document (continuously updated and revised to reflect evolving needs) that "anyone has the ability to change" based on the residents' care needs identified during the staff meetings, care conferences, incident investigations, and grievance reports. She expected the charge nurses on duty to supervise the CNAs and to ensure that they followed the residents' care plans. 18. Review of resident 22's 10/25/25 care plan indicated that he required "cares in pairs" for transferring, repositioning in the shower chair, and to complete all activities of daily living (ADLs), and that two staff members were required to help him transfer using the sit-to-stand lift. 19. Review of resident 22's medical record revealed a 1/6/26 lift evaluation by nursing staff which specified he was "Total dependent (full body lift)." The evaluation was completed after resident 22 sustained a lower left leg hematoma when CNA U bumped his leg with the wheelchair pedals while transferring him to the shower chair. The evaluation read, "Resident will use a total lift going forward for all transfers with two staff until his left leg heals. Once his leg heals, he may go back to using the standing lift for transfers to and from his chairs. He will use the total lift for all transfers to and from bed." A 1/7/26 progress note read, "Resident [22's] care plan has been revised to reflect he is no longer using the sit-to-stand lift for transfers until the hematoma [from the 1/6/26 injury] is healed on the left leg. Staff will perform transfers using [a full	F0689		

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F0689 SS = SQC-K	Continued from page 12 body] lift with two staff assist." Another lift evaluation completed by nursing staff on 2/19/26 specified resident 22 was "Total dependent (full body lift)." A 4/14/26 progress note indicated that, "Resident [22] may now use the [sit-to-stand lift] for all transfers utilizing two staff for all transfers." A 4/25/26 progress note revealed, "Resident [22]...states that CNA [NN] hooked him up to [sit-to-stand lift] and used the wrong hook. States it was way too tight [and] he told the CNA that it was the wrong hook but she stated it would be ok. Also there [are] supposed to be two people at all times when caring for this resident. CNA [NN] was alone in the room with no assistance." 20. Review of resident 22's 4/23/26 physician orders revealed that his lower left leg hematoma from the 1/6/26 injury had not healed and required daily treatment and future evaluation at a local wound care clinic. 21. Review of the provider's 5/14/25 Care Plans policy revealed that, "It is the responsibility of all direct care members to familiarize themselves with the care plans and review them routinely for changes," and that "Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur." 22. Review of the provider's 1/24/26 SD DOH FRI report regarding resident 56 revealed he followed another resident's family out of the south exit door on 1/24/26 at 2:25 p.m. and the temperature outside was three degrees. There was a sign on the exit door that informed the staff and visitors not to assist residents to exit. Resident 56 walked around the building independently and returned through the north door of the facility at 2:40 p.m. Resident 56 was wearing sweatpants, a long sleeve sweatshirt, a ball cap, socks, and sneakers. His Brief Interview for Mental Status (BIMS) assessment score was 2 which indicated his cognition was severely impaired. His vital signs (measurements of the body's function, such as temperature, blood pressure, pulse and respiration rate) were taken. Temperature was 96.9, blood pressure was 137/66, respirations were 20,	F0689		

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F0689 SS = SQC-K	Continued from page 13 and his pulse was 78. His oxygen saturation (percentage of oxygen in the blood) rate was 96%. A head-to-toe skin assessment indicated his skin was warm and dry with a pink color. Resident 56 was placed in a recliner, and given a warm blanket, and his feet were elevated. Resident 56's family and physician were notified of the incident and his physician ordered a wander guard (a wearable door alarm device) to wear on his right wrist. Resident 56's diagnoses included unspecified dementia (a group of symptoms affecting memory, thinking and social abilities), hypertension (elevated blood pressure), type two diabetes mellitus (a condition involving disruptions in how the body regulates blood sugar), COPD (a group of lung diseases that block airflow and make it difficult to breathe), depression, and anxiety (anticipation of future danger or misfortune with feelings of distress and /or sadness and symptoms such as restlessness or irritability) disorder. Elopement drills performed by the staff were last conducted on 1/19/26 and the exit door audits were completed on 1/12/26 and 1/19/26. The interdisciplinary team (IDT) conducted a quality assurance and performance improvement (QAPI) meeting and identified the root cause of resident 56's elopement incident was due to the staff deactivating the front door alarm during the facilities daytime hours to allow visitors to enter and exit the facility. This practice was discontinued, and the staff were educated to keep the door alarm activated. On 1/29/26 staff completed elopement education and repeated the monthly elopement drill to reinforce the importance of always knowing the location of assigned residents and promptly locating anyone whose whereabouts are unknown. Door audits are being performed regularly. 23. Review of resident 56's EMR revealed he was admitted to the facility on 9/18/25. His 6/18/25 facility care plan indicated he had a potential for elopement and was revised on 1/9/26 and 1/26/26 addressing his history of elopement's. The 9/18/25 care plan interventions instructed the staff to ensure that the resident wore an identification bracelet, to have the resident follow a familiar routine, keep photographs of the resident's family and/or their significant other to help provide one to one care, maintain a calm environment, avoid stimulation by other physically aggressive residents, to place the resident on a therapeutic unit, provide the resident with his robotic dog, and to provide activities that resembled the residents prior lifestyle.	F0689		

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F0689 SS = SQC-K	Continued from page 14 On 1/25/26, a wander guard was added to the care plan and instructed staff to check the placement since the resident would remove it and place it on his ankle. The 1/26/26 initiated care plan interventions included the resident's family suggesting referrals be sent out to memory care locked units, the staff to check on the resident every 30 minutes, to maintain the elopement binder, and to have his family/friends sign the resident in and out of the facility. 24. Interview and record review on 4/29/26 at 11:45 a.m. with DON B revealed on 1/24/26, the door alarms were deactivated at the time of resident 56's elopement. The facility tried to redirect resident 56's wandering and agitation by having his significant other come and visit with him. Resident 56 would attend activities and would sit with management at times. He received a physician's order for a wander guard on 1/24/26 after his elopement. 25. Review of the provider's revised 5/14/25 Elopement policy revealed "The facility must take steps to keep the resident safe and assess residents to identify those who are risk for elopement. Facility personnel must investigate all reports of missing residents. Elopement drills should be conducted monthly." 26. Review of the provider's 1/31/26 SD DOH FRI revealed on 1/31/26 at approximately 12:00 a.m., resident 59 was found sitting on the floor between her bed and the bathroom. RN QQ conducted a full body assessment. Resident 59 stated she hit the left side of her head and was transferred to the hospital for further evaluation because she was taking a blood thinning medication. The physician at the hospital documented that all imaging that was completed "was clear." Resident 59 returned from the hospital with a new physician's orders for an antibiotic to treat a urinary tract infection. Resident 59 admitted to the facility on 1/6/26 with diagnoses that included acute embolism and thrombosis of unspecified deep veins (a sudden, serious condition where a blood clot forms obstructing blood flow) of the right lower extremity (leg), unspecified dementia, and epilepsy (a neurological condition characterized by unprovoked sudden, brief disturbances in brain activity). On	F0689		

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F0689 SS = SQC-K	Continued from page 15 1/19/26, resident 59 tested positive for COVID and "remained in isolation precautions on 1/30/26." Resident 59 fell six times while on COVID isolation precautions. Upon investigation, it was determined that resident 59 was last assisted to the bathroom at approximately 9:00 p.m. Resident 59 said she was trying to get up to use the restroom. Her care plan was reviewed and identified her as a high risk for falling related to her poor safety awareness, unsteady gait, decreased strength, and dementia. The interventions implemented included safety checks every 30 minutes and scheduled toileting every two hours. Resident 59's care plan was reviewed and updated to reflect that her bed was to be in the lowest position and a fall mat was to be used. Resident 59 was to be in the "common areas" throughout the day to lower her fall risk. The staff was assigned education to follow the residents' care plans. Resident 59 had "no new falls since [the] education and implementation of interventions." 27. Review of resident 59's closed EMR revealed that she admitted to the facility on 1/6/26 and discharged from the facility on 2/17/26. Her 1/12/26 BIMS assessment score was 0, and her 2/17/26 BIMS assessment score was 3, which both indicated her cognition was severely impaired. Her diagnoses included dementia, protein-calorie malnutrition, and acute embolism and thrombosis of unspecified deep veins of the right lower extremity. Her 1/12/26 MDS assessment (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) indicated the resident did not fall in the last month in the month before her admission to the facility. She fell 11 times between 1/11/26 and 2/10/26 while she resided at the facility. Resident 59's fall risk assessments were completed on 1/11/26, 1/21/26, 1/23/26, 1/24/26, 1/25/26, 1/31/26, 2/7/26, and 2/10/26. Those fall risk assessments indicated that resident 59 was a "Low Risk" for falling. Resident 59's fall incident reports and interventions implemented to prevent subsequent falls included that on 1/11/26 at 7:15 p.m., resident 59 had an	F0689		

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F0689 SS = SQC-K	Continued from page 16 unwitnessed fall and was found on the floor in her room near her bed. The root cause of that fall was listed as "Mental Status, lower extremity weakness." "Hourly checks added to care plan." The section labeled "Describe interventions to prevent future falls" remained blank. On 1/21/26 at 11:20 a.m., resident 59 had an unwitnessed fall and was found on the floor in her room. "Resident [59 was] on covid precautions. "Changed hourly checks to q30 [every 30] minutes." There was no documentation that a root cause analysis was completed. The section labeled "Describe interventions to prevent future falls" remained blank. On 1/21/26 at 8:45 p.m., resident 59 had an unwitnessed fall and was found on the floor in her room. There was no documentation that a root cause analysis was completed. The interventions to prevent future falls indicated "No changes to care plan. Resident [59] continued on Q30 [minute] checks. CNAs to check on [resident 59] more freq [frequently] and in bed earlier in [the] HS [evening]." On 1/22/26 at 10:15 p.m., resident 59 had an unwitnessed fall and was found on the floor in her room. The root cause of that fall was listed as "toileting status." The section labeled "Describe interventions to prevent future falls" indicated "continued on 30 min checks." On 1/23/26 at 5:30 p.m., resident 59 had an unwitnessed fall and was found on the floor in her room. There was no documentation that a root cause analysis was completed. The interventions to prevent future falls indicated, "Res [resident 59 was] assessed for injuries-no injuries [were] noted, Res [resident 59 was] able to move all extremities, no c/o [complaints of] pain. Res assisted from floor to recliner, neuros [neurological evaluation (assessment of nerve function, reflexes, coordination, motor skills, sensation, and mental status) started." On 1/24/26 at 4:15 p.m., resident 59 had a witnessed fall in the doorway of her room. There was no documentation that a root cause analysis was completed. The interventions to prevent future falls, indicated, "reminded [resident 59] not to self transfer. Care plan was followed [and] no changes [were made] to [the] care plan." On 1/25/26 at 10:00 a.m., resident 59 had an unwitnessed fall and was found on the floor in her room. There was no documentation that a root cause analysis was completed. The interventions to prevent	F0689		

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F0689 SS = SQC-K	Continued from page 17 future falls indicated, "[Resident 59 was] placed on q2 [every two] hour toileting [schedule]." "Covid + [positive] ends 1/30 [1/30/26]. Care plan revised." On 1/31/26 at 12:00 a.m., resident 59 had an unwitnessed fall with an injury. She was found sitting on the floor between her bed and the bathroom. "Resident stated she hit her head pretty hard and pointed to the left side of her head." There was no documentation that a root cause analysis was completed. The interventions to prevent future falls, indicated "Resident toileted, reminded to call for assistance. Sent to ER [emergency room] for evaluation." On 2/7/26 at 12:45 a.m., resident 59 had an unwitnessed fall and was found on the floor in her room. There was no documentation that a root cause analysis was completed. The interventions to prevent future falls indicated, "resident [59] continued to try to get up on her own, she is on q2h toileting schedule and on q 30 min safety checks. [A] fall mat [was] placed next to [her] bed." On 2/8/26 at 5:30 p.m., resident 59 had a witnessed fall onto her knees in front of her wheelchair. There was no documentation that a root cause analysis was completed. The interventions to prevent future falls, indicated, "reminded res [resident 59] to ask for help and [to] use [the] call light. [The] care plan was followed, no changes [were made] to [the] care plan." On 2/10/26 at 4:00 p.m., resident 59 had a witnessed fall onto the floor by the nurses' station. There was no documentation that a root cause analysis was completed. The interventions to prevent future falls indicated, "staff [members] have been calling [resident 59's] family to come be with her to help with 1:1 [one to one] supervision, she is discharging [on] 2/17 [2/17/26]." Resident 59's care plan indicated a 1/6/26 focus area: "I am at high risk for falls related to: Poor safety awareness, Unsteady gait, decreased strength, and Dementia." "I have had falls from self transferring attempts R/T [related to] poor safety awareness, and I was on covid isolation when some of my falls occurred," was added on 2/10/26. A 1/6/26 goal was to "Prevent further falls until next review." Interventions on 1/6/26 included: "Use of assistive device during ambulation to prevent falls," "Skilled Rehabilitation Therapy evaluation and	F0689		

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F0689 SS = SQC-K	Continued from page 18 treatment as indicated," and to "Keep call light within reach when in bedroom or bathroom." New interventions were added on 1/15/26, "I will need hourly safety checks to ensure my needs are met," was four days after resident 59's 1/11/26 fall. On 1/23/26, "I will need every 30 minute safety checks to ensure my needs are met," was added after resident 59 had 5 falls. On 1/26/26, "I will have Foresite (an AI-powered, passive sensor system designed for senior care to detect falls and proactively monitor health changes without infringing on privacy) monitoring in my room," was added. On 1/27/26, "I self-transfer often to use the bathroom and don't remember to use my call light. I will be toileted every 2 [two] hours," was added. On 2/6/26, "Keep bed at lowest position when resting and place a fall mat beside the bed," was added after resident 59 had 7 falls. There was no documentation that interventions were added to resident 59's care plan after her 1/31/26 fall with injury that required an emergency room visit. There was no documentation that interventions were added to resident 59's care plan after her 2/7/26, 2/8/26, or 2/10/26 falls. 28. Interview and review of resident 59's fall documentation on 4/28/26 at 2:45 p.m., with DON B and RNC C revealed they expected a new fall risk assessment to be completed after each resident fall. They confirmed resident 59 had 11 falls, and that eight fall risk assessments had been completed. DON B was unsure why resident 59's eight fall risk assessments indicated resident 59 was a low risk for falling after she had 11 falls. DON B considered resident 59 at high risk for falls because she had frequent falls. RNC C felt that the questions were answered correctly in the documented fall risk assessments and stated that the computer program had determined that resident 59 was a low risk for falling. They agreed that their clinical assessments of resident 59 did not match the computer-generated assessment of resident 59's risk for falling. DON B felt that resident 59 was frequently falling "because she wanted to." She stated that resident 59 "did what she wanted" and that her family was aware that she was frequently falling in the facility. She was unsure if resident 59's dementia played a role in her falls or if she was having behaviors that included falling because she wanted to return home.	F0689		

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F0689 SS = SQC-K	Continued from page 19 DON B felt that adequate interventions were put in place to ensure resident 59's safety and to reduce her risk for falling. 29. Review of the provider's 2/16/26 falls Quality Assurance and Performance Improvement (QAPI) Ad hoc Meeting Minutes revealed "Proactiv[e] for admission to ensure that the Fall risk assessment is completed and care plan reflects interventions to prevent falls or limit falls as residents have the right to fall." "What system changes were made/modified?" indicated "Fall policy reviewed." "[One] 1 resident [59], who was admitted for rehab, had 11 falls. [Eight] 8 falls in Jan [January] 2026 and 3 [Three] falls in Feb. [February] 2026. Her discharge date is 2/17/26..." 30. Review of the provider's 5/14/25 Falls Management policy revealed: "It is the policy of the facility to identify and implement appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence." "Determine and implement new intervention for fall prevention and record on [the] care plan.	F0689		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to protect the	F0600	1. Resident #21 was immediately assessed following the allegation of inappropriate sexual touching by contracted travel CNA E. The allegation was reported to the South Dakota Department of Health, local law enforcement, Dakota at Home, the resident's responsible party, and the contracted staffing agency on 4/21/26. Resident #21 was offered counseling services and monitored for psychosocial well-being. A skin assessment was completed. Contracted travel CNA E was immediately suspended from the facility on 4/21/26 and placed on the facility's do not return/do not rehire list for all affiliated facilities. Staff members who failed to timely report the allegation in accordance with facility abuse policy were immediately removed from duty pending investigation and were later terminated for failure to follow mandatory abuse reporting requirements. All residents are at risk for deficient practice. On 4/21/26, nursing management completed resident interviews	6/2/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0600 SS = SQC-J	Continued from page 20 resident's right to be free from sexual abuse for one of one sampled resident (21) who reported he was touched in a private area without his consent by one of one contracted travel certified nursing assistant (CNA) (E). Immediate Jeopardy (IJ) at F600, with a scope and severity of "J", began on 4/21/26 at 9:17 a.m. upon observation of resident 21 in the hallway when he reported to registered nurse (RN) D that he had a concern of being touched by a staff member on 4/21/26. Resident 21 reported that contracted travel CNA E had touched him in a private area without his consent, which upset the resident. The provider failed to report and investigate the allegation of abuse to other entities, provide education to all staff, interview any further residents and staff regarding the allegation, and provide safety to resident 21 and all the residents to prevent similar situations from occurring. Administrator A was notified of the IJ on 4/21/26 at 3:28 p.m. and a removal plan was requested. The removal plan was received on 4/21/26 at 6:38 p.m. by email. The edited removal plan was received on 4/21/26 at 6:55 p.m., and it was accepted on 4/21/26 at 7:01 p.m. The IJ was removed on 4/21/26 at 10:00 a.m. as confirmed by onsite verification by the survey team. After the IJ removal, the scope and severity of the noncompliance remained at a G. The resident census was 45. Findings include: 1. Observation on 4/21/26 at 9:17 a.m. of resident 21 in the hallway revealed he reported to RN D that contracted travel CNA E had touched him in a private area without his consent, which upset him (resident 21). RN D told the resident they had "handled that situation." 2. Interview on 4/21/26 at 10:02 a.m. with resident 21 revealed that he was touched in a private area without his consent by one of one contracted travel certified nursing assistant (CNA) (E). At 6:00 a.m. on	F0600	throughout the facility to identify any additional concerns related to inappropriate touching, abuse, neglect, or staff misconduct. Residents with cognitive impairment were included to the extent possible, with documentation completed for residents unable to participate. No additional allegations or concerns were identified. 2. The facility determined the deficient practice occurred because staff failed to recognize and act upon mandatory abuse reporting requirements requiring immediate escalation of allegations involving potential resident abuse. Contributing factors included inadequate understanding of reporting timelines and supervisory responsibilities, inconsistent reinforcement of abuse prevention expectations among facility and contracted staff, and failure to promptly implement the facility abuse reporting chain of command upon initial disclosure of the allegation. The Administrator, DON and interdisciplinary team, in collaboration with the governing board and medical director, reviewed policies and procedures to ensure residents are free from abuse. Policies and procedures address care techniques for residents, including but not limited to appropriate staff-to-resident interaction, timely reporting of all allegations of abuse to all applicable entities, timely notification to all applicable parties, and processes to ensure complete and thorough investigations to mitigate the risk of future abuse. Educations and training was provided to all staff that fosters understanding of what may constitute abuse that specifically addresses sexual abuse and includes, but is not limited to, appropriate methods related to determining incontinence care needs, appropriate staff-to-resident interaction, and abuse prevention. Competencies of staff knowledge within 30 days upon hire, annually and as needed. Additionally, orientation and ongoing education processes for contracted staff were not sufficiently standardized to ensure consistent understanding of resident rights, consent during care, abuse reporting obligations, and immediate protective actions. 3. Administrator/designee will audit abuse	

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F0600 SS = SQC-J	Continued from page 21 4/21/26, he woke up with a "quick startle when someone had their hands in my pants. I said, what the hell are you doing?" He said that contracted travel CNA E replied, "I am trying to see if you are wet." Resident 21 then stated to CNA E, "I said you get the hell out of here," and per resident 21, CNA E left his room. The resident said that CNA E did not stop to explain anything to him. He stated that CNA E "groped" him with her hands down his pants and it made him "feel cheap." He said he does not normally "get checked" for incontinence (involuntary urine or bowel leakage) at night. He was awake for an early morning blood sugar checks or blood lab draws, but not for going to the bathroom, because he used a urinal at night. 3. Interview on 4/21/26 at 11:18 a.m. with RN D revealed resident 21 had stopped her in the hallway and said that he was woken up at 6:00 a.m. that morning by a lady's hands down his pants. There was a contracted travel CNA working on the 4/20/26 night shift and RN D stated that "we did speak with the traveler and normally he [resident 21] is able to take himself to the bathroom and put his call light on if he needs help to go to the bathroom." RN D knew resident 21 reported the allegation to RN F, who then had the conversation with the contracted travel CNA. RN D did not report this allegation to director of nursing (DON) B, but RN D was aware of the provider's process to inform the DON of the situation. The DON would then visit with the resident and contact the resident's family about the incident. RN D was aware that facilities had two hours to report allegations of abuse to the South Dakota Department of Health (SD DOH). The failure to report and investigate the allegation of abuse to the DON regarding the allegation, and provide safety to resident 21 and all the residents to prevent similar situations from occurring. 4. Interview on 4/21/26 at 11:47 a.m. with assistant director of nursing (ADON) G and DON B revealed they became aware of resident 21's abuse allegation at approximately 11:32 a.m. on 4/21/26 when RN D informed them. DON B expected the staff to wake up the residents and obtain their consent before checking to see if they were incontinent. She reiterated that resident 21 was independent and took himself to the bathroom, "so it is not usual that we check his brief." She felt this allegation needed to be reported and she expected RN D to have reported	F0600	allegation reporting and investigation documentation weekly for 4 weeks, then monthly for two additional months, to ensure compliance with facility policy and regulatory reporting timelines. Administrator or designee will conduct abuse and neglect focused interviews for 5 random residents for 4 weeks, then monthly for two additional months. Administrator or designee will present audit findings monthly in QAPI meeting for progress review and further recommendations.	

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F0600 SS = SQC-J	Continued from page 22 the allegation sooner. DON B confirmed that contracted travel CNA E worked the overnight shift on 4/20/26 (started work the evening of 4/20/26, ended work on the morning of 4/21/26). DON B said no one had investigated that allegation so far within the facility, but she attempted to call CNA E. 5. Interview on 4/21/26 at 11:58 a.m. with RN F revealed that around 7:00 a.m. she was in resident 21's room to check his blood sugar and administer his medications. Resident 21 told RN F that someone came into his room at 6:00 a.m. and placed their hands down his pants to ensure he was dry. RN F went to the nursing desk and CNA E was still working from the night shift and the CNA stated, "I didn't know he didn't need checking." RN F did not think it was appropriate for a staff member to put their hands down a resident's pants to check their incontinent products. RN F's process for checking if a resident was incontinent was to knock on the door, turn the light on so the resident could see her, ask them if they needed to use the restroom, and then get them up if they were able. If she could not wake the resident up, she would get another staff member to assist her with checking and changing the resident's incontinent product. RN F confirmed she did not report the allegations to anyone else after talking with CNA E. She explained that she was going to tell the DON, and then the DON could update the CNA pocket care plans (a document that identifies residents' care needs and interventions). RN F did not know the reporting time frame for allegations. 6. Review of resident 21's electronic medical record revealed that he was admitted on 9/9/25. His diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities), unspecified psychosis not due to a substance or known physiological condition (a state of losing touch with reality that is not related to substance use or health condition), insomnia (trouble sleeping), and anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability).	F0600		

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F0600 SS = SQC-J	Continued from page 23 His care plan included an intervention revised on 12/16/25 that indicated he required assistance with two staff members via a pivot transfer using a gait belt to transfer. A 9/18/25 intervention indicated that he required "partial assist" with personal hygiene, dressing, and transfers. A 9/18/25 focus area indicated that "[Resident 21] is at risk for alteration of bowel and bladder functioning related to Dementia, BPH [benign prostatic hyperplasia], [and] incontinence," and an associated intervention indicated to "remind, offer and assist with toileting as needed." His 2/25/26 quarterly Minimum Data Set assessment included that his Brief Interview for Mental Status assessment score was 13, which indicated his cognition was intact. His blood sugar measurement documentation confirmed that RN F checked his blood sugar on 4/21/26 at 7:03 a.m. 7. Interview on 4/21/26 at 1:34 p.m. with administrator A revealed she was informed of resident 21's incident by RN D at 11:15 a.m. and submitted a report to the SD DOH at 12:45 p.m. RN D had educated the resident on their process for checking residents for incontinence needs and changing their incontinence products. Administrator A did not contact the local law enforcement agency regarding the incident. She stated she would not report such allegations of abuse to law enforcement until their investigation determined if abuse occurred. She had not yet initiated interviews with resident 21, other residents, or the staff to investigate the allegation further. IMMEDIATE JEOPARDY: On 4/21/26 at 3:28 p.m., administrator A as notified of the IJ and a removal plan was requested. The IJ removal plan was received on 4/21/26 at 6:38 p.m. by email. The edited IJ removal plan was received on 4/21/26 at 6:55 p.m., and it was accepted on 4/21/26 at 7:01 p.m. REMOVAL PLAN: "Avantara Watertown IJ Removal Plan 1. Resident 21's allegation of sexual abuse was	F0600		

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F0600 SS = SQC-J	Continued from page 24 reported to the South Dakota Department of Health (DOH), Coddington Police Department, Dakota at Home, his wife, and provider on 4/21/26. Resident 21's skin assessment to be completed 4/21/2026. His previous skin assessment was completed by registered nurse (RN) on 4/3/26 with multiple scattered bruises noted to the body. Resident number 21 will be offered counseling services. Certified Nursing Assistant (CNA) E was immediately suspended on 4-21-2026 and placed on the DNR [do not return/rehire] list for all Avantara facilities, as she is an agency C.N.A from ClipBoard [a contracted travel nursing company]. RN (F) was suspended for not reporting allegations of abuse and neglect to the Administrator or DON and RN (D) was suspended for not reporting the allegation in a timely manner. 2. On 4/21/26, Nurse Managers completed interviews on all residents to determine if they had concerns regarding inappropriate touch by a staff member or whether they had witnessed another resident being touched inappropriately by a staff member. Nurse Managers included residents with low cognitive capabilities. For residents unable to respond, they documented attempt and unable to respond on the interview questionnaire. No other residents voiced concerns. Nurse Managers/DON completed interviews with all staff working evening and night shift on 4/21/2026 to determine if a resident has ever reported that they had been touched inappropriately, whether they have ever witnessed a staff member touching a resident inappropriately, and if they know who to report abuse concerns to and that abuse allegations need to be reported immediately. Director of Nursing (DON) or designee will complete interviews with all remaining staff prior to their next shift worked to determine if a resident has ever reported that they have been touched inappropriately, whether they have witnessed a staff member touch a resident inappropriately, and if they know who and when to report abuse concerns to. 3. Regional Nurse Consultant educated the Administrator and DON on the Abuse and Neglect policy, including immediate reporting and investigating, to ensure interventions are implemented to safeguard all residents from abuse that continues to put all residents at risk on 4/21/26. Regional Nurse Consultant educated all Nurse Managers on the Abuse and Neglect policy, including immediate reporting requirements, to ensure all residents remain free from abuse and/or neglect on 4/21/26. DON or designee started immediate education with all staff working the	F0600		

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F0600 SS = SQC-J	Continued from page 25 evening/night shift on 4/21/2026 on the Abuse and Neglect policy, including immediate reporting and investigating, to ensure all residents remain free from abuse and/or neglect. Admin, DON, or designee will educate all other facility and contract staff on the Abuse and Neglect policy, including immediate reporting and investigating, to ensure all residents remain free from abuse and/or neglect prior to their next shift worked. DON or designee will ensure new staff, including contract staff, receive education on the Abuse and Neglect policy, including immediate reporting requirements, prior to their first shift worked. DON or designee will interview 5 random residents each week to ensure they remain free from abuse and/or neglect and feel safe in the facility. Additionally, the DON or designee will observe 5 CNAs each week on random shifts to ensure residents are approached and touched appropriately when assisting them with incontinence care. These interviews and audits will continue for four weeks and then monthly for three months. Results of audits will be reviewed by the Administrator, DON or designee with IDT [interdisciplinary team] and Medical Director at monthly Quality Assurance Performance Improvement (QAPI) for analysis and recommendation for continuation/discontinuation/revision of audits based on findings." The immediacy was removed by onsite verification through observations, interviews, and documentation review on 4/22/26 at 10:00 a.m. After the IJ removal, the scope and severity of the noncompliance remained at a G. 8. Review of the provider's 5/14/25 Abuse and Neglect policy revealed the policy statement read, "It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation." The policy had five steps to take if abuse/neglect was suspected that included: "1. Take immediate steps to assure the protection of	F0600		

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F0600 SS = SQC-J	Continued from page 26 the resident(s). This may involve separation from the alleged abuser and/or provision of medical care. 2. Notify the appropriate/designated organization/authority that an investigation is being initiated immediately following intervention for the resident's safety. 3. Conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses. 4. Notify law enforcement authorities if indicated (i.e., a crime such as physical or sexual abuse, theft, etc.). 5. Report the investigation findings to all necessary state and/or local agencies and any other identified persons as required by law." The "Steps in Abuse Prevention" included Screening, Training, Prevention, Identification, Investigation, Protection, and Reporting/Response. "...V. Investigation: Have procedures to: Investigate all allegations of abuse, neglect, exploitation, and misappropriation of property. Identify [the] staff responsible for [the] investigation. All allegations will be investigated by the Administrator or Designee immediately..." "...VI. Protection: Have procedures to: Protect residents from physical and psychosocial harm during the investigation..." "...VII. Reporting/Response...Have procedures to: All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee. All allegations of abuse will be reported to your state agency immediately (within 2 hours) after the initial allegation is received. A final investigation report will be submitted to your state agency within 5 working days. If the event that results in [an] allegation of abuse also causes the individual to suspect a crime, the facility will also report to the local law enforcement agency. Report to [the] State Nurse Registry and/or Department of Professional Regulations if the employer has knowledge of any action by the court of law against the licensed employee."	F0600		

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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 observation, interview, record review, policy review, and manufacturer's instructions review, the provider failed to ensure residents were free from significant medication errors for one of one sampled resident (7) who was not administered his physician-ordered carbidopa/levodopa (a medication to treat Parkinsons disease; a progressive movement disorder) and clonazepam (a medication used to treat anxiety and tremors) according to the medications' administration schedules which resulted in increased tremors (shaking), muscle spasms (sudden, involuntary, and often painful contraction of one or more muscles), and anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and for one of one sampled resident (3) who was administered the incorrect physician-ordered dose of insulin by licensed practical nurse (LPN) (W) which increased his risk for having diabetic complications, including hypoglycemia (an abnormally low blood sugar level). Findings include: 1.Observation and interview on 4/21/26 at 8:19 a.m. with resident 7 in his room revealed his right foot repeatedly tapped on the floor and he had tremors to his upper extremities. His voice was soft, and he spoke slowly. He had a percutaneous endoscopic gastrostomy (PEG) tube (a tube surgically placed through the abdomen into the stomach to administer liquid nutrition, fluids, and medications). He often received his medication late, especially at night. 2. Review of resident 7's electronic medical record (EMR) revealed he admitted to the facility on 9/29/25. His 2/3/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. He had a 9/29/25 physician's order for carbidopa/levodopa 25-100 milligrams (mg) one and one-half tablets to be administered every four hours through his PEG tube for his Parkinsons disease and a 3/31/26 physician's order for	F0760	1. Resident #7, #3 medication errors could not be corrected. Resident #7 was assessed for adverse emotional concerns on 5/20/2026 and he refused services or activities to assist with psychosocial support. Resident #7's pharmacist, and care team reviewed the medication administration schedule for carbidopa/levodopa and clonazepam. Resident #7 was monitored for adverse effects related to late medication administration. Resident #3 was immediately assessed after receiving the incorrect dose of insulin and no adverse outcome occurred. The involved nurse received immediate counseling and re-education regarding insulin administration, blood glucose documentation, and medication administration safety practice. All residents have the potential to be affected. A facility-wide audit was completed for residents receiving time-sensitive medications, including Parkinson's medications, and insulin to ensure medications were administered within ordered timeframes. Last 30 days of medication error reports were reviewed to identify trends. Any concerns identified were addressed immediately. 2. The Administrator, DON, and interdisciplinary team, in collaboration with the medical director and consulting pharmacist, will review, revise, and/or create policies and procedures as necessary to ensure consistent and accurate administration of medication as ordered, administration of medications occurs within the required timeframe for the medications' scheduled administration times to ensure residents are administered medications according to the intended schedule and as ordered, to mitigate risk of negative outcomes, and accurate documentation and processes, to include but not be limited to blood sugar level documentation and administering sliding scales insulin according to ordered parameters, to ensure residents receive insulin as ordered to mitigate risk of negative outcomes. Education to all staff who administer medication about their roles and responsibilities regarding those policies, education and processes.	6/2/2026

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F0760 SS = G	Continued from page 28 clonazepam 0.5 mg one-half tablet to be administered every six hours for tremors. Resident 7's April 2025 medication administration record (MAR) indicated that on 4/11/26 at 4:00 p.m. his dose of carbidopa/levodopa was not documented as administered. Resident 7's 4/7/26 physician's visit by medical director (MD) LL indicated resident 7 reported "crampy sensation in the ankle and foot with tremors", and he was "currently tapering clonazepam, [he] expressed concerns about possible increased anxiety and tremors". His general appearance was described as "frail appearing gentleman with jerking movements and tremors sitting in [his] wheelchair." "Clonazepam dose reduction initiated as per GDR [gradual dose reduction]. Monitor for increased anxiety or tremors." Resident 7's medication administration times from 4/1/26 through 4/22/26 indicated that his midnight scheduled dose of carbidopa/levodopa was administered late (more than one hour before or after scheduled) on 4/9/26 when it was administered at 1:39 a.m., on 4/13/26 when it was administered at 3:52 a.m., (the same time his scheduled 4:00 a.m. dose of carbidopa/levodopa was documented as administered), on 4/15/26 when it was administered at 1:15 a.m., and on 4/17/26 when it was administered at 2:10 a.m. Resident 7's 4:00 a.m. scheduled carbidopa/levodopa was administered late on 4/8/26 when it was administered at 5:02 a.m., on 4/9/26 when it was administered at 5:45 a.m., on 4/12/26 when it was administered at 1:37 a.m., on 4/14/26 when it was administered at 5:22 a.m., on 4/16/26 when it was administered at 5:20 a.m., and on 4/21/26 when it was administered at 5:18 a.m. Resident 7's 8:00 a.m. scheduled carbidopa/levodopa dose was administered late on 4/3/26 when it was administered at 9:29 a.m., on 4/6/26 when it was administered at 9:07 a.m., on 4/9/26 when it was administered at 9:21 a.m., on 4/10/26 when it was administered at 9:30 a.m., on 4/11/26 when it was administered at 9:38 a.m., on 4/12/26 when it was administered at 9:21 a.m., on 4/13/26 when it was administered at 9:14 a.m., and on 4/14/26 when it was administered at 9:41 a.m. Resident 7's 12:00 p.m. scheduled carbidopa/levodopa dose was administered late on 4/11/26 when it was administered at 1:32 p.m., and on 4/16/26 it was administered at 1:24 p.m.	F0760	Competencies of staff knowledge within 30 days upon hire, annually and as needed. The facility reinforced that nurses in orientation or training must complete medication administration competency within 30 days of hire, annually, and as needed until competency is verified. Nursing leadership reviewed the process for monitoring medication administration reports and identifying repeated late medication administrations for follow-up and corrective action will be taken. 3. DON/designee will audit 5 residents' medication administration records to ensure medications are being administered per physicians' orders, insulin administration and blood glucose verification for 4 weeks, then monthly for two additional months. DON or designee will present audit findings monthly in QAPI meeting for progress review and further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435068	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0760 SS = G	Continued from page 29 Resident 7's 4:00 p.m. scheduled carbidopa/levodopa dose was administered late on 4/3/26 when it was administered at 9:18 p.m. (the 4/3/26 8:00 p.m. scheduled dose was documented as administered at 8:02 p.m.), on 4/4/26 when it was administered at 5:19 p.m., on 4/7/26 when it was administered at 5:01 p.m., on 4/10/26 when it was administered at 5:09 p.m., on 4/13/26 when it was administered at 5:02 p.m., on 4/17/26 when it was administered at 5:18 p.m., and on 4/18/26 when it was administered at 5:06 p.m. Resident 7's 8:00 p.m. scheduled carbidopa/levodopa dose was administered late on 4/5/26 when it was administered at 10:31 p.m., on 4/8/26 when it was administered at 10:41 p.m., on 4/11/26 when it was administered at 10:17 p.m., on 4/12/26 when it was administered on 4/13/26 at 12:05 a.m., and on 4/16/26 when it was administered at 11:20 p.m. Resident 7 did not have any late administrations of his 5:00 a.m. scheduled clonazepam. Resident 7's 11:00 a.m. scheduled clonazepam dose was administered late on 4/1/26 when it was administered at 12:14 p.m., on 4/2/26 when it was administered at 12:17 p.m., on 4/3/26 when it was administered at 12:24 p.m., on 4/4/26 when it was administered at 12:17 p.m., on 4/5/26 when it was administered at 12:07 p.m., on 4/6/26 when it was administered at 12:10 p.m., on 4/7/26 when it was administered at 12:27 p.m., on 4/8/26 when it was administered at 12:23 p.m., on 4/9/26 when it was administered at 12:49 p.m., on 4/10/26 when it was administered at 12:46 p.m., on 4/11/26 when it was administered at 1:32 p.m., on 4/14/26 when it was administered at 12:08 p.m., on 4/15/26 when it was administered at 12:20 p.m., on 4/16/26 when it was administered at 1:24 p.m., on 4/17/26 when it was administered at 12:25 p.m., on 4/18/26 when it was administered at 12:18 p.m., and on 4/19/26 when it was administered at 12:23 p.m. Resident 7's 5:00 p.m. scheduled clonazepam dose was administered late on 4/3/26 when it was administered at 6:44 p.m., and on 4/11/26 when it was administered at 6:08 p.m. Resident 7's 11:00 p.m. schedule clonazepam dose was administered late on 4/1/26 when it was administered at 1:01 a.m. on 4/2/26, when his 4/8/26 dose was administered on 4/9/26 at 1:43 a.m., when his 4/9/26 dose was administered on 4/10/26 at 12:05 a.m., when his 4/10/26 dose was	F0760		

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F0760 SS = G	Continued from page 30 administered on 4/11/26 at 12:02 a.m., when his 4/11/26 dose was administered on 4/12/26 at 1:39 a.m., when his 4/12/26 dose was administered on 4/13/26 at 12:31 a.m., when his 4/14/26 dose was administered on 4/15/26 at 1:15 a.m., and when his 4/17/26 dose was administered on 4/18/26 at 12:54 a.m. 3. Interview on 4/27/26 at 2:36 p.m. with resident 7 revealed he had received his 4/26/26 8:00 p.m. medications two hours and forty-five minutes late. When his mediations were late, he started sweating, his tremors and jerking movements got worse, the late medication administration and movements "kicks up" his "metabolism" and it made him feel like he needed to urinate but due to his increased tremors and jerking movements it was hard for him to use his urinal. This made him feel, "not good". 4. Interview on 4/28/26 at 2:31 p.m. with licensed practical nurse (LPN) N revealed the residents' medications were expected to be administered within one hour before or one hour after their scheduled administration times. She attempted to administer resident 7's medication as close to the scheduled time as possible because if his medications were late, his nerves would start "acting up". He would become more nervous, and his movements would become more pronounced. 5. Interview on 4/29/26 at 8:24 a.m. with licensed pharmacist JJ revealed he was the consultant pharmacist for the provider. He expected the residents' medications to be administered within one hour before or one hour after their scheduled administration time. Carbidopa/levodopa was to be administered on a schedule because it was a time sensitive medication. If carbidopa/levodopa was not administered on schedule the resident may develop adverse symptoms. He explained that the negative outcomes regarding clonazepam may not be as significant as carbidopa/levodopa if it was administered late, but it should be administered within an hour before or an hour after the scheduled time. He acknowledged that a resident attempting a GDR of clonazepam may not have an accurate interpretation of symptoms if the resident was not receiving his clonazepam or carbidopa/levodopa as ordered by the physician. 6. Interview on 4/29/26 at 10:09 a.m. with director of	F0760		

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F0760 SS = G	Continued from page 31 nursing (DON) B revealed she was told three or four days ago that the night nurse gave resident 7's medication late. She expected resident 7's carbidopa/levodopa to be given within 15 minutes of when it was scheduled. She did not know if resident 7 experienced any symptoms related to those medications being administered late. She stated he does not leave his room, and that she expected resident 7's medications to be administered as scheduled. DON B acknowledged that resident 7's clonazepam not being administered as scheduled may alter the outcome of his attempted GDR because the staff would not be able to determine if his increased symptoms were the result of the decreased medication dose or the inconsistent administration times of his medications. 7. Interview on 4/29/26 at 11:47 a.m. with MD LL revealed she was resident 7's physician revealed the carbidopa/levodopa dose and the scheduled administrations times were based on each person's symptoms. She verified resident 7 was attempting a GDR of his clonazepam. She expected carbidopa/levodopa and clonazepam to be administered within 30 minutes of their scheduled time. If they were not given as scheduled, resident 7 could feel cramps, restlessness, tremors, and have right leg spasms when his medications were not administered at their scheduled times. The carbidopa/levodopa and clonazepam not being administered as scheduled could alter the outcome of his GDR attempt because she would not be able to determine if resident 7's symptoms were related to the GDR, or the late administration of the medications. She considered missed and late doses of carbidopa/levodopa and clonazepam significant medication errors. 8. Review of the provider's 4/11/25 Medication Variance report for resident 3 indicated, "At 5:50 PM, resident [3's] BS [blood sugar level] was 122 and [he] was given 7 units of Humalog (a rapid-acting, prescription insulin analog used to improve blood sugar control) when [he] did not need any insulin..." Resident 3's "BS number was mixed up with [his] roommates' BS number that was 258." The director of nursing, resident 3's daughter, and the resident's physician were notified. 9. Review of resident 3's EMR revealed he admitted	F0760		

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F0760 SS = G	Continued from page 32 to the facility on 6/22/23. His 6/12/24 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) had a focus area that indicated he had diabetes. An 11/13/25 revised intervention indicated "Please administer diabetic medications as ordered per MAR." There was an 11/24/23 physician's order for resident 7 to be given a "HumaLOG Injection Solution 100 UNIT/ML [milliliter] (Insulin Lispro) Inject as per sliding scale [an individualized insulin regimen that adjusts the dose based on the resident's blood sugar level]: if 0 - 70 = Call MD [medical doctor]; 71 - 150 = 0 Units; 151 - 200 = 3 Units; 201 - 250 = 5 Units; 251 - 300 = 7 Units; 301 - 350 = 9 Units; 351 - 400 = 11 Units; 401 - 999 = Call MD, subcutaneously [under the skin] four times a day related to TYPE 2 DIABETES MELLITUS WITH OTHER DIABETIC KIDNEY COMPLICATION." His 1/12/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. His diagnoses included Type 2 Diabetes Mellitus with other diabetic kidney complications. Resident 3's MAR revealed that on 4/11/26 at 5:30 p.m., his blood sugar level was recorded as 258, and he was administered 7 units of Humalog insulin. There was a 4/11/26 physician's order to "Recheck BS 30 min after eating supper and again 1 hour after eating supper. One time a day related to TYPE 2 DIABETES MELLITUS WITH OTHER DIABETIC KIDNEY COMPLICATION." Those blood sugar levels were documented as 209 at 7:32 p.m. and 242 at 8:30 p.m. on 4/11/26. 10. Phone interview on 4/28/26 at 11:59 a.m. with LPN W, revealed she was in training with registered nurse (RN) EE on 4/11/26. They had gone into resident 3's room together. LPN W checked resident 3's blood sugar level while RN EE checked the roommate's (resident 4), blood sugar level before that evening's meal. LPN W stated she was "rushing" to complete that task, and when she returned to the computer, she entered resident 4's blood sugar level of 258 into resident 3's EMR, and based on resident 3's physician's ordered sliding scale, she administered seven units of Humalog insulin to resident 3. She realized right away she had given resident 3 insulin based on resident 4's blood sugar level. Resident 3 did not require any insulin for his blood sugar level of 122. She immediately notified RN EE of what she had done.	F0760		

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F0760 SS = G	Continued from page 33 RN EE contacted DON B, resident 3's daughter, and the resident's physician. The physician ordered that additional blood sugar levels be monitored. Resident 3 was allowed an extra ice cream at dinner, and his blood sugar levels were within an acceptable range. LPN stated she was still in training and had been told by RN WW and DON B that she needed to slow down and complete one resident's blood sugar level readings at a time. 11. Interview on 4/28/26 at 2:45 p.m. with DON B and regional nurse consultant C revealed LPN W was a new nurse and was receiving training by RN EE. DON B was notified on 4/11/26 by RN EE that LPN W administered an incorrect dose of insulin to resident 3. She ensured that resident 3's daughter, his physician, and the medical director were notified, and that the Medication Variance form had been completed. DON B educated RN EE and LPN W to slow down and to only check one resident's blood sugar level at a time. LPN W did not complete the Licensed Nurse Skills Competency Checklist because she was still in training. 12. Interview on 4/28/26 at 4:50 p.m. with RN EE revealed that on 4/11/26, she was training LPN W. LPN W told RN EE that she documented resident 4's blood sugar level of 258 in resident 3's EMR and administered 7 units of insulin to resident 3 based on his physician's ordered insulin sliding scale. Resident 3's blood sugar level was 122, and he should not have received any insulin. RN EE did not expect LPN W to administer insulin without her present, because LPN W was still training. She felt that LPN W was in a hurry. She knew that administering seven units of insulin to resident 3 when he did not require insulin was a significant medication error that could have caused resident 3's blood sugar level to drop too low. She contacted DON B, resident 3's daughter, and his physician immediately. Resident 3's blood sugar levels were monitored, he was provided with additional dessert, and his blood sugar levels did not drop. 13. Interview on 4/29/26 at 8:33 a.m. with licensed pharmacist JJ revealed that resident 3 receiving seven units of insulin when his BS was 122, could be considered a significant medication error. He felt that the significance would depend on how quickly	F0760		

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F0760 SS = G	Continued from page 34 that error was recognized and what steps were taken after it occurred. He felt that the correct actions were taken quickly after the error was discovered by LPN W and RN EE, but that there could have been a significant negative outcome for resident 3 because his blood sugar levels could have dropped too low. 14. Review of RN EE's 8/27/25 Licensed Nurse Skills Competency Checklist revealed she had met all competency criteria listed under the use of a Subcutaneous Insulin Pen. 15. Review of the provider's December 2019 Medication Administration-General Guidelines policy revealed the "FIVE RIGHTS- Right resident, right drug, right dose, right route and right time, are applied for each medication being administered." "Medications are administered within [60 minutes] of scheduled time, except before, with or after meal orders, which are administered [based on mealtimes]." "If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time (e.g., the resident is not in the facility at the scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administrations is initialed and circled. If electronic MAR is used, documentation of the unadministered dose is done as instructed by the procedures for use of the eMAR system. 16. Review of the provider's 5/14/25 Medication Errors policy revealed "Each medication error discovered will be documented on the Medication Error Report form. The person discovering the error will complete Part 1 of the Form." "Part 3 of the Form will address how this error occurred and can be prevented in the future. This section will be completed by the nurse/medication aide most closely responsible for the error." 17. Review of the 4/7/26 Carbidopa and Levodopa manufacturer's instructions revealed it is important that carbidopa/levodopa "be taken at regular intervals according to the schedule outlined by the physician. The patient should be cautioned not to change the prescribed dosage regimen" "Patients should be advised that sometimes a 'weaning-off' effect may occur at the end of the dosing interval."	F0760		

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F0760 SS = G	Continued from page 35 18. Review of the provider's January 2018 Specific Medication Administration Procedures policy revealed that, related to injectable medication administration, the purpose was to "administer medications via subcutaneous, intradermal and intramuscular routes in a safe, accurate, and effective manner." "Check order on the medication administration record to see that an injection is currently ordered and due... Prepare the resident...Check 5 rights..." 19. Review of the provider's 1/14/26 Safe Injection Practices policy revealed it did not contain specific information regarding the administration of insulin.	F0760		
F0583 SS = F	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the	F0583	1. The facility census document containing protected health information (PHI), including resident names, admission dates, and payer sources, was immediately removed from the publicly accessible area on 4/27/2026 and secured in an authorized staff-only location. No evidence was identified that resident information had been improperly accessed, disclosed, or misused. All residents were identified as having the potential to be affected by the deficient practice. An audit of nursing stations, common work areas, printers, desks, hanging file systems, and other documentation storage areas was completed to identify unsecured documents containing resident protected health information. No additional breaches or unsecured PHI concerns were identified during the audit process. The facility implemented revised monitoring and document handling practices to reinforce secure storage, prompt removal of unsecured documents, and staff accountability related to protection of resident confidential information. Beginning 5/13/2026, all staff were re-educated regarding resident privacy rights, HIPAA requirements, confidentiality of protected health information, and secure handling, storage, and disposal of documents containing PHI by the Administrator or designee, with training continuing until all staff have completed the required education. 2. The facility reviewed and reinforced expectations regarding resident privacy, confidentiality, and secure storage of PHI.	6/2/2026

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F0583 SS = F	Continued from page 36 Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure all residents' right to privacy and confidentiality of protected health information (an individual's health, treatment, and payment information, also known as PHI) were protected related to a facility census document that was stored in an area accessible to anyone who passed by. Findings include: 1.Observation on 4/27/26 at 11:35 a.m. near the nurse's desk revealed a hanging file organizer that contained a facility census report with resident private information, including name, admission date, and payer source. That report was not in a secure location and could have been accessed by anyone. 2. Interview on 4/27/26 at 11:42 a.m. with administrator A revealed that the document contained confidential information and was in an area that was accessible to the public. She agreed this was a violation of resident confidentiality. 3. Review of the provider's 11/18/25 Medical Records: Storage & Destruction policy revealed that the resident's record set was "comprised of the resident's medical and billing record," and that "the facility will maintain the confidentiality of all information contained in the medical record." 4. Review of the provider's 11/18/25 Resident Dignity & Privacy policy revealed that "Protected Health Information should not be in [the] viewing area of [the] public."	F0583	Nursing station organization practices were reviewed and revised to ensure confidential documents remain in secured staff-only areas. Leadership reinforced staff responsibility to immediately remove or report unsecured PHI if identified. The Administrator, DON, and interdisciplinary team, in collaboration with the governing board and medical director, reviewed applicable policies and procedures to ensure residents' rights are protected and honored. Verified policies and procedures addressed processes and expectations for identifying and honoring residents' rights including but not limited to resident' dignity, privacy, and self-determination of choices and preferences, and accommodating those preferences related to bathing process preferences, privacy, and dignity; providing adequate education to residents and/or their representatives for informed decisions regarding consent for treatments such as psychotropic medication use; and maintaining protected health and payor source information privately and confidentially. Education was provided to all staff about their roles and responsibilities regarding those policies, procedures, and processes. Competencies of staff knowledge completed within 30 days upon hire, annually and as needed. 3. Administrator/designee will conduct random privacy and confidentiality audits for 4 weeks, then monthly for 2 additional months, including nursing stations, shared work areas, printers/copiers, census reports, and resident record storage areas. Findings will be reviewed monthly in QAPI meeting for further recommendations and ongoing compliance.	
F0835 SS = F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial	F0835	1. See previous deficiencies' plan of corrections for immediate actions, educations and audits that pertain to identified deficiencies. No other immediate actions could be taken. 2. See previous deficiencies' plan of corrections for planned education on noted deficiencies. VPO (Vice President of Operations) or designee will review Administrator job description with Administrator.	6/2/2026

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F0835 SS = F	Continued from page 37 well-being of each resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure the facility was operated and administered by administrator A and director of nursing (DON) B in a manner that ensured quality of life and overall well-being for all 45 residents in the facility. Findings include: 1. Observations, interviews, record reviews, and policy reviews throughout the survey on 4/21/26 through 4/23/26 and 4/27/26 through 4/29/26 revealed administrator A and DON B did not ensure the management, safety, quality of life, and overall well-being of all the residents who lived at the facility. Those were evidenced by a widespread system breakdown to ensure services provided met professional standards as it pertained to resident dignity, informed decision for psychotropic medications, resident self-administration of medications, resident meal choices/preferences, responses to resident concerns after resident council meetings, resident health information security, how to file a grievance, allegations of resident abuse, consent/diagnoses for psychotropic medications, reporting allegations timely, Ombudsman reports upon discharge, accurate Minimum Data Set (MDS) assessments (a federally mandated clinical assessment tool for nursing home residents, used to evaluate functional capabilities)/PASSR (Pre-Admission Screening and Resident Review) (a federally mandated assessment required before admission to a Medicaid-certified nursing facility to ensure proper placement for individuals with serious mental illness or intellectual disabilities), PASSR refiling due to new resident diagnoses, resident specific baseline care plans within 48 hours of being admitted to the facility, updating resident care plans, notifying a physician of a resident's increased blood sugar levels, accident hazards related to bed side rails, nebulizer and nasal canula cleaning and storage, bed siderail assessments, orders and consent, call light wait times, controlled substance accountability, medication errors, and the storage of drugs and biologicals. 2. Interview on 4/29/26 at 9:30 a.m. with administrator A revealed she had worked at this	F0835	3. VPO, RNC (Regional Nurse Consultant) or designee will visit weekly either in person or via phone to check on progress and needs of the facility. VPO, RNC or designee will complete a visit report for each visit. Visits will be weekly for 4 weeks and then monthly for 2 months. VPO, RNC or Designee will discuss results through monthly QAPI for further review of progress and discussion of continuation/discontinuation of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435068	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0835 SS = F	Continued from page 38 facility for approximately five years, left in 2021 to open a facility for another provider, and had returned to this facility in October of 2025. She confirmed she was responsible for the daily operations of the facility. She stated the siderail issue was frustrating because the company specifically bought new siderails to be compliant. 3. Review of the providers 4/23/25 updated administrator job description revealed, "In keeping with our organization's goal of improving the lives of the residents we serve, the Administrator provides overall direction for all activities related to administration personnel, physical structure, information systems, office management and marketing of the entire facility. The Administrator works closely with all members of the management team and others to ensure their responsibilities are effectively and consistently discharged. The Administrator will ensure all facility operations are in compliance with federal, state and local regulations." 4. Review of the providers 12/1/19 updated director of nursing job description revealed "In keeping with our organization's goal of improving the lives of the Guests we serve, the Director of Nursing plays a critical role in providing superior customer service and nursing services to all Guests in the facility. The Director of Nursing is responsible for the planning, development and overall operation of the Nursing Department which ensures Guests receive quality care 24 hours a day." Refer to F550, F552, F554, F583, F585, F600, F605, F609, F628, F641, F644, F655, F657, F658, F689, F695, F700, F755, F759, F760, F761, and F806.	F0835		
F0837 SS = F	Governing Body CFR(s): 483.70(d)(1)-(3) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required;	F0837	1. See previous deficiencies' plan of corrections for immediate actions, educations and audits that pertain to identified deficiencies. No other immediate actions could be taken. 2. See previous deficiencies' plan of corrections for planned education on noted deficiencies. 3. VPO, RNC (Regional Nurse Consultant) or designee will visit weekly either in person or via phone to check on progress and needs of the facility. VPO, RNC or designee will complete a visit report for each visit. Visits will be weekly for 4 weeks and then monthly for 2 months. VPO, RNC or Designee will discuss results through monthly QAPI for further review of progress and discussion of continuation/discontinuation of audits.	6/2/2026

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F0837 SS = F	Continued from page 39 (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. §483.70(d)(3) The governing body is responsible and accountable for the QAPI program, in accordance with §483.75(f). This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record reviews, and policy reviews, the governing body failed to ensure the facility was operated in a manner that ensured the safe management and overall well-being of 45 residents in the facility. Findings include: 1. Observations, interviews, record reviews, and policy reviews throughout the survey on 4/21/26 through 4/23/26 and 4/27/26 through 4/29/26 revealed administrator A and DON B did not ensure the management, safety, quality of life, and overall well-being of all the residents who lived at the facility. Those were evidenced by a widespread system breakdown to ensure services provided met professional standards as it pertained to resident dignity, informed decision for psychotropic medications, resident self-administration of medications, resident meal choices/preferences, responses to resident concerns after resident council meetings, resident health information security, how to file a grievance, allegations of resident abuse, consent/diagnoses for psychotropic medications, reporting allegations timely, Ombudsman reports upon discharge, accurate Minimum Data Set (MDS) assessments (a federally mandated clinical assessment tool for nursing home residents, used to evaluate functional capabilities)/PASSR (Pre-Admission Screening and Resident Review) (a federally mandated assessment required before admission to a Medicaid-certified nursing facility to ensure proper placement for individuals with serious mental illness or intellectual disabilities), PASSR refiling due to new resident diagnoses, resident specific baseline care plans within 48 hours of being admitted to the facility, updating resident care plans, notifying a physician of a resident's increased blood sugar levels, accident hazards related to bed side rails, nebulizer and nasal canula cleaning and storage, bed siderail assessments, orders and consent, call light wait	F0837		

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F0837 SS = F	Continued from page 40 times, controlled substance accountability, medication errors, and the storage of drugs and biologicals. 2. Interview on 4/29/26 at 9:30 a.m. with administrator A revealed she stated when she returned to the administration position she was informed by corporate staff that there were some serious issues to work on and to utilize the corporate consultants for help. Social services had a consultant review the job expectations and they had reached out to another social services consultant for help. The dietary consultant was in the building every two or three weeks mentoring the dietary manager. The registered dietitian's services had been expanded to focus on areas that were identified. The activities consultant had also been there to do an orientation. The regional nurse consultant had been there on a regular basis. There was an administrator consultant in the building when she came back to the position. She had called other area company administrators and they had been to the building to offer guidance. The minimum data set (MDS) coordinator consultant was coming once a month and had weekly calls. Every department checked in with a peer monitor/consultant at least once a week based on the standup meetings. 3. Review of the providers 4/23/25 updated administrator job description revealed, "In keeping with our organization's goal of improving the lives of the residents we serve, the Administrator provides overall direction for all activities related to administration personnel, physical structure, information systems, office management and marketing of the entire facility. The Administrator works closely with all members of the management team and others to ensure their responsibilities are effectively and consistently discharged. The Administrator will ensure all facility operations are in compliance with federal, state and local regulations." 4. Review of the providers 12/1/19 updated director of nursing job description revealed "In keeping with our organization's goal of improving the lives of the Guests we serve, the Director of Nursing plays a critical role in providing superior customer service and nursing services to all Guests in the facility. The Director of Nursing is responsible for the planning, development and overall operation of the Nursing Department which ensures Guests receive quality care 24 hours a day." Refer to F550, F552, F554, F583, F585, F600, F605, F609, F628, F641, F644, F655, F657, F658, F689, F695, F700, F755, F759, F760, F761, and F806.	F0837		

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F0865 SS = F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices;	F0865	1. See previous deficiencies' plan of corrections for immediate actions, educations and audits that pertain to identified deficiencies. No other immediate actions could be taken. 2. All IDT including the Administrator will be educated by RNC or designee on the elements of an effective QAPI program. This education will be completed no later than June 2, 2026. 3. RNC or designee will attend QAPI monthly for 3 months and then quarterly after to review the process and provide feedback to the Administrator and IDT on areas of opportunity. RNC or designee will discuss results during monthly QAPI for further review of progress and discussion of continuation/discontinuation of audits.	6/2/2026

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F0865 SS = F	Continued from page 42 §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure	F0865		

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F0865 SS = F	Continued from page 43 of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on interview and quality assurance and performance improvement (QAPI) plan policy review, the provider failed to ensure they had identified and corrected quality deficiencies when they occurred throughout the facility and that performance improvement projects (PIP) were thoroughly identified, implemented, or monitored related to quality of care, quality of life, and safety concerns for areas affecting residents such as siderails on residents' beds, incident reporting, medication administration and storage, and baseline care plans. 1. Interview on 4/29/26 at 9:30 a.m. with administrator A regarding the QAPI program and committee revealed that she was the QAPI coordinator for the provider and that each department manager conducted their own audits. She reviewed and consolidated the reports to be discussed at the QAPI meeting. The QAPI committee reviewed the reports and implemented any plan needed for correction. The provider's QAPI committee was comprised of all the department managers, administrator A, director of nursing (DON) B, the medical director, pharmacist, consultant dietitian, and regional nurse consultant. They review the QAPI minutes and from there discuss resident care, quality of life or safety issues that had been identified and created a PIP team to investigate the issues. They had improvement in the 5star quality measures in quality of care going from 1 star to 4 stars. They had seen downward trending as well in wounds and falls so, the QAPI committee was currently working on Ad Hoc (PIP) projects that included resident wounds and reducing resident falls. Regarding areas of non-compliance identified by the survey team that included siderails on the residents' beds, incident reporting, medication administration and storage, and baseline care plans, she stated they relied on the maintenance department to do the siderail inspections as part of a monthly checkoff. They were struggling with the siderail issue because the maintenance department utilized a grid system from the Food and Drug	F0865		

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F0865 SS = F	Continued from page 44 Administration (FDA) for the siderail inspections. The grid system did not identify the 4.75 inch as a maximum height for an opening in the siderail. She confirmed the QAPI committee did not currently have siderails, incident reporting, medication administration and storage, and baseline care plans identified as concerns to review and monitor. 2. Review of the provider's undated QAPI Plan revealed, "Our vision is to lead healthcare back to a place where people are treated like people-one where care is more personal, empathetic, and customized to every individual." "We believe that each resident/patient entrusted to our care is given our full attention in all that we do. To that end, our key values include: Service excellence to our residents/patients, Quality care in a caring environment, A work environment that encourages excellence, Dedication and responsiveness, Enthusiasm: When you love what you do, you have more to give, Commitment: When you believe you can make a difference, you do make a difference!" "The QAPI Steering Committee will have oversight of the QAPI program and shall consist of representation from Nursing, Infection Control, Consulting Pharmacist, Compliance Officer, Dietary, Housekeeping, Laundry, Maintenance, Social Services, Activities and Administration. The Administrator has responsibility and is accountable to our corporation for ensuring that QAPI is implemented throughout our organization. Our facility Medical Director will also serve on the QAPI Steering Committee to provide guidance and direction where necessary." "When the need is identified, we will implement corrective action plans or performance improvement projects to improve processes, systems, outcomes and satisfaction. An interdisciplinary subcommittee will be developed to work on Performance Improvement Projects (PIPs) at the discretion of the QAPI Steering Committee..." Refer to F585, F600, F609, F655, F689, F700, F755, F759, F760, and F761.	F0865		
F0550 SS = E	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 facility, including those specified in this section.	F0550	1. Residents #22, #3, and #37 were interviewed regarding bathing preferences, privacy expectations, and personal dignity concerns. Resident bathing preferences related to location of undressing, privacy during transport, and personal care routines were reviewed and updated in the residents' care plans as indicated. Staff involved received education by the RNC regarding resident dignity, privacy,	6/2/2026

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F0550 SS = E	Continued from page 45 §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. §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. §483.10(b) Exercise of Rights. 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. §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. §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. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, interview, record review, and policy review, the provider failed to ensure that staff protected three of four sampled resident's (3, 22, 37) right to a sense of dignity, respect, and self-determination regarding bathing preferences. Findings include: 1. Review of the provider's 1/6/25 SD DOH FRI revealed that resident 22 informed director of nursing (DON) B that on his bath days, certified nurse aide (CNA) U had undressed him in his room,	F0550	individualized bathing preferences, and resident choice during personal care activities. All residents were identified as having the potential to be affected by the deficient practice. Nursing management completed resident interviews throughout the facility to identify any additional concerns and resident bathing preferences, privacy expectations, and personal care routines. No new concerns or allegations were identified during the audit process. Resident care plans were reviewed and updated as indicated to reflect individualized bathing preferences, privacy during transport, location of undressing and dressing, use of coverings, and resident participation in personal care. Beginning 5/13/2026, all staff were re-educated by the Administrator or designee regarding resident rights, dignity, privacy, and resident choice during personal care activities, with training continuing until all staff have completed the required education. 2.The Administrator, DON, and interdisciplinary team, in collaboration with the governing board and medical director, reviewed applicable policies and procedures to ensure residents' rights are protected and honored. Verified policies and procedures addressed processes and expectations for identifying and honoring residents' rights including but not limited to resident' dignity, privacy, and self-determination of choices and preferences, and accommodating those preferences related to bathing process preferences, privacy, and dignity; providing adequate education to residents and/or their representatives for informed decisions regarding consent for treatments such as psychotropic medication use; and maintaining protected health and payor source information privately and confidentially. Education was provided to all staff about their roles and responsibilities regarding those policies, procedures, and processes. Competencies of staff knowledge completed within 30 days upon hire, annually and as needed. 3. DON/designee will conduct random bathing observations weekly for 4 weeks, then monthly for two additional months. DON or designee will present audit findings monthly in QAPI meeting for progress review and further recommendations.	

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F0550 SS = E	Continued from page 46 covered him with a blanket, then transported him to the shower room. Resident 22 stated he was uncomfortable going through the hallway covered with only a blanket and that he preferred to get undressed in the shower room. According to the FRI, CNA U had been made aware of the concern and was educated to respect the resident's preference. 2. Interview on 4/21/26 at 2:15 p.m. with resident 22 revealed that CNA U continued to undress him in his room, cover him with a blanket, and transport him to the shower room. He said it made him uncomfortable and that "it happens all the time." 3. Interview on 4/27/26 at 2:16 p.m. with CNA U revealed that she was aware of resident 22's preference to undress in the shower room rather than his room. She stated that all residents were undressed in the shower room. 4. Interview on 4/28/26 at 10:30 a.m. with CNA M revealed that residents with limited mobility use a medical device called a mechanical lift to transfer between beds, wheelchairs, toilets, and shower chairs. She stated that residents "typically get undressed in their room, especially if they're a lift [require a lift to transfer them to the shower chair], then they get undressed in their room and we cover them with a blanket to take them to the shower room." 5. Interview on 4/28/26 at 4:15 p.m. with resident 3 revealed that he had seen resident 22 transported to the shower room with "a blanket over his body [which] means he's undressed." Resident 3 stated that CNA U did not ask resident 3 where he preferred to undress for his baths; instead, "she just comes in and says, 'It's time for your bath,' and starts getting me undressed." Resident 3 said that CNA U "can be a little picky," so he does what she tells him to do. 6. Interview on 4/28/26 at 4:20 p.m. with resident 37 revealed that he undressed in his room. He stated, "[CNA U] just takes me out of the bed and puts me into the chair to transport, then covers me with a white sheet and takes me to the tub room," without asking him his preferences. He stated that he had also seen other residents transported to the shower room covered by a white sheet.	F0550		

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F0550 SS = E	Continued from page 47 7. Interview on 4/29/26 at 8:19 a.m. with DON B revealed that the bathing protocol was to follow the resident's preference to undress in their room or the shower room. She stated that she had educated CNA U that resident 22 preferred to undress in the shower room and said, "Sometimes it might be easier to undress the resident in their room, but [the staff] should follow what the resident wants." 8. Review of resident 22's 10/25/25 care plan revealed that he required partial assistance with upper body dressing and full assistance with lower body dressing. His care plan did not indicate any bathing preferences other than frequency. 9. Review of the provider's 11/18/25 Resident Dignity & Privacy Policy revealed that, "It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity." The policy indicated that staff were to groom and dress residents according to their preference and to maintain resident privacy when providing care.	F0550		
F0585 SS = E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F0585	1. Residents identified with concerns regarding call light response times, toileting assistance, incontinent care, or knowledge of the grievance process were interviewed by facility leadership, and concerns were addressed as identified. Residents were re-educated on grievance reporting options, including verbal, written, and anonymous submissions, the location of grievance forms, and contact information for the Grievance Official and outside agencies. All residents were identified as having the potential to be affected by the deficient practice. A facility-wide review was conducted of call light response processes, resident access to grievance forms, anonymous grievance submission methods, grievance tracking practices, and resident understanding of the grievance process. Any concerns identified during the review were addressed promptly. All staff were re-educated regarding timely response to resident needs, resident rights related to grievances, grievance reporting requirements, and prompt escalation of unresolved concerns.	6/2/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435068	A. BUILDING B. WING	04/29/2026

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F0585 SS = E	Continued from page 48 §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken	F0585	2. The facility reinforced its grievance management process to improve resident access, timely resolution of concerns, and management oversight. Grievance forms were made more accessible by posting them in the dining room at wheelchair-accessible height and providing a secure anonymous grievance drop box. Grievance signage was updated to include submission options. A grievance process letter was distributed to residents and families and incorporated into the admission process. Staff were re-educated on the grievance process, reporting requirements, documentation expectations, and required response timelines. Leadership reinforced expectations for timely investigation, follow-up, and review of grievance trends through routine management and QAPI oversight. 3. Administrator/designee will conduct random call light response audits, grievance documentation audits for timely resolution and notification, and resident interviews weekly for 4 weeks, then monthly for 2 additional months. Findings and grievance trends will be reviewed monthly in QAPI meeting for further recommendations and ongoing compliance.	

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F0585 SS = E	Continued from page 49 by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, resident council meeting interview, and policy review, the provider failed to: *Ensure prompt response to call light times, and that the necessary cares and services were provided within a timely manner for four of four residents (2,16, 24, and 61) to maintain their physical, mental, and emotional well-being. *Implement an effective grievance process to ensure residents' have the knowledge on how to file a grievance, where the grievance forms are located at and a process in place on how to file grievances anonymously. Findings Include: 1. Interview on 4/21/26 at 9:38 a.m. with resident 16 revealed "the problems with living in this facility is that she is not getting help when she needs it." She revealed that sometimes she had to wait an hour to have staff come to help her in her room. She used her call light for the staff to help her change positions, or to help with personal cares from being incontinent (involuntary urine or bowel leakage) of urine. She said, "I will just be soaking wet" and she voiced her peri-area (perineum, the skin between the genitals and anus) will burn until she gets help. 2. Interview on 4/21/26 at 10:12 a.m. with resident 24 revealed "they [the staff] don't answer their call lights. They put me in a diaper [incontinent product] and when I am in the bathroom I have to wait because I can't put a new one on myself. I have sat on the toilet for 25 minutes after I'm done just waiting for someone to come. They have more people living here than they have the help to keep	F0585		

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F0585 SS = E	Continued from page 50 up. If I am in the dining room and ask for a cup of hot water, they just walk away. Another resident will ask again for me and then I will finally get it." 3. A resident council meeting was held on 4/22/26 at 4:00 p.m. revealed resident 2 voiced complaints about her concerns of call light response times being 30 minutes. Resident 61 voiced complaints about her call light response times being 45 minutes. 4. Interview on 4/28/26 at 10:07 a.m. with licensed practical nurse (LPN) KK revealed that she would expect the staff to respond to call lights in no more than five minutes. 5. Interview on 4/28/26 at 10:17 a.m. with certified nursing assistant (CNA) K revealed that she would expect the staff to respond to call light in no more than five minutes. 6. Interview on 4/28/26 at 1119 a.m. with the director of nursing B revealed that the residents should not have to wait longer more than five to ten minutes for a call light to were responded to for help. 7. Interview on 4/28/26 at 1130 a.m. with activities director (AD) GG revealed that the concerns about the call lights taking too long to be responded to had been consistent. AD GG revealed she had voiced this as an issue as well in the facility stand up meetings. She said that she had witnessed resident 29 waiting in his room with his family, with his call light on for fifteen to twenty minutes prior to staff arriving to assist with his needs. 8. Interview on 4/29/26 at 9:00 a.m. with administrator A revealed call light wait time grievances were a trend she recognizes, they have increased the call light audits and managers to do this task more frequently, but due to nurse management loss was not as frequent. 9. Interview on 4/29/26 at 9:27 a.m. with the social service designee (SSD) J revealed that she saw the call light times and extended wait times as a trend with grievances. 10. Request for call light logs for residents revealed the facilities call light system does not track the location or timing information of the call light activation or the response time. 11. Review of the call light audits completed from November 2025 through April 2026 revealed that in April 2026 of the sixteen observations completed five response times were ten minutes, six minutes and	F0585		

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F0585 SS = E	Continued from page 51 fifty-seven seconds, six minutes, and seven minutes. Review of the March 2026 call light audit revealed that of the four observations completed one response time was ten minutes and thirty-seven seconds. March audit frequency was to be completed one time per week by designated manager and 1 time on a weekend by the manager on duty (MOD). No complete weekend audit provided. Review of the February 2026 call light audit revealed that no audits were provided for this month. Review of the January 2026 call light audits revealed of the six observations completed three were seven minutes and four seconds, six minutes and five seconds, and eight minutes and two seconds. Review of the December 2025 call light audits revealed of the four observations completed one response time was seventeen minutes and thirty-two seconds and one response time was thirty-six minutes and sixteen seconds. December audit frequency was to be completed one time per week by designated manager and one time on a weekend by the manager on duty (MOD). No completed weekday audit provided. Review of the November 2025 audits revealed of the twenty audits completed three were nine minutes and fifteen seconds, six minutes and forty seconds, and seven minutes and forty seconds. 12. Review of the resident council's meeting minutes from October 2025 through March 2026 revealed there were recurring topics of concerns with waiting for food to be served at meals times, types of food being served, and call light wait times. 13. Review of the provider's October 2025 through April 2026 grievances revealed fourteen of forty-four grievances were various concerns of quality of cares being given to the residents, nine of the forty-four grievances were related to long wait times. 14. Review of the provider's 11/18/2025 Call Light Policy revealed 1. The facility shall answer call lights in a timely manner. If immediate assistance cannot be provided and there is not an emergent need, call light may be turned off and resident informed that staff member will be back to assist them shortly. 4. Ensure call lights are placed within reach of residents. 5. Ensure that when the call light is triggered, it will either alert the staff visually or audibly or both.	F0585		

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F0585 SS = E	Continued from page 52 15. Interview on 4/21/26 at 9:44 a.m. with resident 16 revealed she did not know how to fill out a grievance form to notify the facility of her concerns. 16. A resident council meeting held on 4/22/26 at 4:00 p.m. revealed that six of six residents did not know how to file a grievance or where the grievance forms were located. 17. Interview on 4/27/26 with social service designee (SSD) J revealed the location of the grievance forms was "probably not" accessible to all the residents due to the height of them hanging on the wall in a file organizer by the nurses station. She said, "I never thought of that." When asked if the residents were able to file a grievance anonymously SSD J stated "There is no drop box where they could put it, so they would have to give it to somebody, and they probably couldn't access it from the wheelchair anyways." SSD J revealed she provided education to the activities director (AD) GG regarding the process on how to help the resident council file a grievance if they needed to. If she had grievances from the resident council and she was aware which resident they were regarding she would follow up with that specific resident on the grievance resolution, but if not, she would give the grievance resolution to AD GG to review with the resident council members at their next resident council meeting. 18. Interview on 4/27/26 at 3:03 p.m. with administrator A revealed that she did not think the grievance forms were accessible to the resident who were in a wheelchair and there was no process for a resident to file a grievance anonymously. 19. Interview on 4/28/26 at 4:33 p.m. with SSD J revealed that she expected the grievance form to include the date the resolution was provided, the discussion with the complainant, including whether they wanted a written copy, and if they were satisfied with the resolution. 20. Review of the grievance documentation for the forty-four grievances reviewed revealed that seven of the forty-four grievances reviewed did not have notification to the complainant or resident, sixteen of the forty-four residents did not have documentation if the complainant or resident wanted written communication of the resolution, fourteen of the forty-four grievances reviewed did not document if	F0585		

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F0585 SS = E	Continued from page 53 the person notified of the resolution was satisfied with the outcome. 21. Review of the provider's 5/14/25 Grievances Policy revealed "2. The facility will notify the residents individually or through postings in prominent locations of the facility to the right to file grievance(s) orally, in writing or anonymously. 2a. The notification will include the name, address, and phone number of the grievance official, a reasonable time frame to investigate the grievance, and the residents right to obtain a written copy of the grievance investigation if requested. 2b. The notification will also include the contact information for agencies where the grievances can also be reported to appropriate state agencies. 4. The administrator or designees shall confer with persons involved in the incident and other relevant persons and within three (3) days of receiving the grievance shall provide a written explanation, upon request, of findings and proposed remedies to the complainant and the aggrieved party, if other than the complainant and legal representative, if any. Where appropriate, due to the mental or physical condition of the complainant or aggrieved party, an oral explanation shall accompany a written one. 5. During the investigation, the facility will put in place immediate action to prevent potential violation of resident rights. 6. If the grievance includes suspected abuse, neglect, injury of unknown source, or misappropriation of property, abuse protocol will be followed. (See abuse and Neglect Policy). 7. All grievance decisions will include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusion regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action to be taken by the facility as a result of the grievance, and the date the written decision was issued. 8. If the grievance is confirmed, the facility will take appropriate corrective action. The facility will maintain results of grievances for 3 years." 22. Review of the provider's 2025 Contract Between Resident and Avantara Watertown revealed "3. The resident may file a grievance regarding any aspect of their care and treatment at the Facility without fear of discrimination or reprisal. For information on filing a grievance, contact [SSD], Avantara Watertown Grievance Officer at 605-886-8431." 23. Review of the provider's 5/14/25 Resident Council policy revealed, "2. Generally staff members do not attend meeting unless they are invited to do	F0585		

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F0585 SS = E	Continued from page 54 so by the council. A staff member is designated as a meeting facilitator and may attend and take notes if desired by the council. 6. The facility will act promptly upon grievances and recommendations expressed from the council in accordance with the facility grievance policy. 7. Appropriate department director or appointed staff will follow up with the individual resident voicing concern(s) to discuss response/resolution. A collective resident council grievance will be follows up with the Resident Council President."	F0585		
F0609 SS = E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to implement procedures to ensure allegations of abuse were reported to the required entities for two separate allegations of abuse: *A sexual abuse allegation made by one of one	F0609	1. Resident #21 was immediately assessed following the allegation of inappropriate sexual touching by contracted travel CNA E. The allegation was reported to the South Dakota Department of Health, local law enforcement, Dakota at Home, the resident's responsible party, and the contracted staffing agency on 4/21/26. Resident #21 was offered counseling services and monitored for psychosocial well-being. A skin assessment was completed. Contracted travel CNA E was immediately suspended from the facility on 4/21/26 and placed on the facility's do not return/do not rehire list for all affiliated facilities. Staff members who failed to timely report the allegation in accordance with facility abuse policy were immediately removed from duty pending investigation and were later terminated for failure to follow mandatory abuse reporting requirements. All residents are at risk for deficient practice. On 4/21/26, nursing management completed resident interviews throughout the facility to identify any additional concerns related to inappropriate touching, abuse, neglect, or staff misconduct. Residents with cognitive impairment were included to the extent possible, with documentation completed for residents unable to participate. No additional allegations or concerns were identified. 2. The facility reinforced its Abuse Prevention Program and mandatory reporting procedures to ensure all allegations, suspicions, observations, or reports of abuse, neglect, exploitation, or mistreatment are immediately reported through the established chain of command. All staff were re-educated regarding resident rights, consent during care, abuse prevention, reporting	6/2/2026

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F0609 SS = E	Continued from page 55 sampled resident (21) to registered nurse (RN) F and RN D involving certified nursing assistant (CNA) E and an unidentified staff member. *A possible financial abuse allegation made by one of one sampled resident's (40) family member to social services designee (SSD) J. Findings include: 1. Observation on 4/21/26 at 9:17 a.m. of resident 21 in the hallway revealed he reported to RN D that contracted travel CNA E had touched him in a private area without his consent, which upset him (resident 21). RN D told the resident they had "handled that situation." 2. Interview on 4/21/26 at 10:02 a.m. with resident 21 revealed that he was touched in a private area without his consent by one of one contracted travel certified nursing assistant (CNA) (E). At 6:00 a.m. on 4/21/26, he woke up with a "quick startle when someone had their hands in my pants. I said, what the hell are you doing?" He said that contracted travel CNA E replied, "I am trying to see if you are wet." Resident 21 then stated to CNA E, "I said you get the hell out of here," and per resident 21, CNA E left his room. The resident said that CNA E did not stop to explain anything to him. He stated that CNA E "groped" him with her hands down his pants and it made him "feel cheap." He said he does not normally "get checked" for incontinence (involuntary urine or bowel leakage) at night. He was awake for an early morning blood sugar checks or blood lab draws, but not for going to the bathroom, because he used a urinal at night. 3. Interview on 4/21/26 at 11:18 a.m. with RN D revealed resident 21 had stopped her in the hallway and said that he was woken up at 6:00 a.m. that morning by a lady's hands down his pants. There was a contracted travel CNA working on the 4/20/26 night shift and RN D stated that "we did speak with the traveler and normally he [resident 21] is able to take himself to the bathroom and put his call light on if he needs help to go to the bathroom." RN D knew resident 21 reported the allegation to RN F, who then had the conversation with the contracted travel CNA. RN D did not report this allegation to director of nursing (DON) B, but RN D was aware of the	F0609	requirements, reporting timelines, and immediate protective actions. Leadership reinforced supervisory responsibilities for prompt escalation, investigation, notification, and follow-up of abuse allegations. 3. Administrator/designee will audit abuse allegation reporting and investigation documentation weekly for 4 weeks, then monthly for 2 additional months, to ensure compliance with facility policy and regulatory reporting timelines. Administrator or designee will conduct abuse and neglect focused interviews for 5 random residents for 4 weeks, then monthly for two additional months. Administrator or designee will present audit findings monthly in QAPI meeting for progress review and further recommendations	

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F0609 SS = E	Continued from page 56 provider's process to inform the DON of the situation. The DON would then visit with the resident and contact the resident's family about the incident. RN D was aware that facilities had two hours to report allegations of abuse to the South Dakota Department of Health (SD DOH). The failure to report and investigate the allegation of abuse to the DON regarding the allegation, and provide safety to resident 21 and all the residents to prevent similar situations from occurring. 4. Interview on 4/21/26 at 11:47 a.m. with assistant director of nursing (ADON) G and DON B revealed they became aware of resident 21's abuse allegation at approximately 11:32 a.m. on 4/21/26 when RN D informed them. DON B confirmed that allegation should have been reported, and she expected RN D to have reported the allegation sooner. DON B said the allegation had not been investigated yet, but she attempted to call CNA E. 5. Interview on 4/21/26 at 11:58 a.m. with RN F revealed that she was in resident 21's room to check his blood sugar and administer his medications at around 7:00 a.m. that morning. She confirmed that resident 21 told her that someone came into his room at 6:00 a.m. and placed their hands down his pants to ensure he was dry. RN F did not think it was appropriate for a staff member to put their hands down a resident's pants to check their incontinent products, and she talked with CNA E about the situation to educate her. RN F confirmed she did not report resident 21's allegations to anyone else after talking with CNA E. She explained that she was going to tell the DON but had not yet. RN F did not know the reporting time frame for abuse allegations. 6. Interview on 4/21/26 at 1:34 p.m. with administrator A revealed that RN D reported resident 21's allegations to her on 4/21/26 at 11:15 a.m. She would have expected staff to recognize that as an abuse allegation and that it should have been reported to the SD DOH within two hours of learning about the allegation. She explained that RN D should have reported resident 21's allegations to herself as the administrator or the nurse on call. She submitted a report to the SD DOH at 12:45 p.m. Administrator A did not contact the local law enforcement agency regarding the incident. She stated she would not report such allegations of abuse to law enforcement	F0609		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA WATERTOWN	415 FOURTH AVE NE , WATERTOWN, South Dakota, 57201

(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
F0609 SS = E	Continued from page 57 until their investigation determined if abuse occurred. She said, "At this point we are going to interview the resident and staff and get part way through the investigation prior to getting them [law enforcement] involved." 7. Review of the provider's 4/21/26 SD DOH facility reported incident (FRI) report revealed that law enforcement and the ombudsman were not notified. 8. Interview on 4/28/26 at 11:19 a.m. with DON B revealed that if they received an allegation of abuse or neglect outside of business hours, she or administrator A would come to the facility to start the investigation process. They started by "writing a reportable." Their investigation process included calling the staff for witness statements, reviewing the cameras, talking to family members, calling the police "if it warrants," and sending a report to the SD DOH and the local ombudsman. She said that "the time of the day doesn't matter" when it came to reporting or investigating an allegation. 9. Review of resident 40's progress notes revealed that on 4/17/26 at 4:55 p.m., social service designee (SSD) J was made aware of concerns from resident 40's family member that there may be suspected financial abuse. SSD J provided the "contact information for the states attorney's office for reporting suspected abuse along with how to file a report with [adult protective services]." 10. Interview on 4/29/26 at 9:00 a.m. with administrator A revealed that resident 40's family member had informed SSD J of a concern with financial abuse on 4/17/26. She said they did not get any details about the potential financial abuse that the resident's family member was worried about, so she did not think she needed to report the abuse allegation to SD DOH. She and SSD J provided resources to the resident's family member about where to report potential financial abuse. 11. Interview on 4/29/26 at 9:27 a.m. with SSD J revealed that on 4/17/26, she notified administrator A of resident 40's family members' concern regarding suspected financial abuse. 12. Review of the provider's 4/28/26 SD DOH FRI revealed that "at approximately 1:00 p.m. on	F0609		

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F0609 SS = E	Continued from page 58 4/28/26, [resident 40] reported concerns that her power of attorney (POA, someone designated on a legal document to act on behalf of a resident) may be misappropriating her funds." 13. Review of the provider's 5/14/25 Abuse and Neglect policy revealed the policy statement read, "It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation." The policy had five steps to take if abuse/neglect was suspected that included: "1. Take immediate steps to assure the protection of the resident(s). This may involve separation from the alleged abuser and/or provision of medical care. 2. Notify the appropriate/designated organization/authority that an investigation is being initiated immediately following intervention for the resident's safety. 3. Conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses. 4. Notify law enforcement authorities if indicated (i.e., a crime such as physical or sexual abuse, theft, etc.). 5. Report the investigation findings to all necessary state and/or local agencies and any other identified persons as required by law." The "Steps in Abuse Prevention" included Screening, Training, Prevention, Identification, Investigation, Protection, and Reporting/Response. "...IV. Identification: Have procedures to: Establish a written policy on how to assist staff in identifying abuse, neglect, exploitation, or misappropriation of property including the types of abuse..." "...V. Investigation: Have procedures to: Investigate all allegations of abuse, neglect, exploitation, and	F0609		

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F0609 SS = E	Continued from page 59 misappropriation of property. Identify [the] staff responsible for [the] investigation. All allegations will be investigated by the Administrator or Designee immediately..." "...VII. Reporting/Response...Have procedures to: All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee. All allegations of abuse will be reported to your state agency immediately (within 2 hours) after the initial allegation is received. A final investigation report will be submitted to your state agency within 5 working days. If the event that results in [an] allegation of abuse also causes the individual to suspect a crime, the facility will also report to the local law enforcement agency. Report to [the] State Nurse Registry and/or Department of Professional Regulations if the employer has knowledge of any action by the court of law against the licensed employee."	F0609		
F0655 SS = E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §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- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services.	F0655	1.Baseline care plans for Residents #2, #4, #7, #33, #40, and #59 were reviewed and corrected as indicated to ensure individualized resident care information was included. Resident and/or representative review, signatures, and documentation were completed as indicated. All residents are at risk for deficient practice. All new admissions are reviewed daily to ensure a signed care plan is completed and copy offered within 48 hours. 2. The facility implemented a revised admission review system to verify baseline care plan completion, resident review, and required documentation within required timeframes. Administrator or designee educated interdisciplinary team members regarding baseline care plan requirements and documentation expectations. Staff not in attendance will be educated prior to their next scheduled shift. 3. Administrator/designee will audit all new admissions for baseline care plan completion, inclusion of individualized resident information, and documentation that copies were offered to the resident and/or representative within 48 hours of admission daily for 4 weeks, then monthly for 2 additional months. Audit findings	6/2/2026

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F0655 SS = E	Continued from page 60 (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §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: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: 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) included the minimum healthcare information necessary to properly care for the resident, and that the care plan was completed within 48 hours of the resident's admission to the facility for six of 19 sampled residents (2, 4, 7, 33, 40, and 59), 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 six of seven newly admitted sampled residents (2, 4, 7, 33, 40, and 59). Findings include: 1. Review of resident 4's electronic medical record (EMR) revealed he was admitted to the facility on 9/25/25. There was an uploaded signed paper copy of his baseline care plan. It was signed by resident	F0655		

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F0655 SS = E	Continued from page 61 4's representative on 9/25/25 to indicate that they had received a copy and that it was reviewed with them. His 9/25/25 baseline care plan did not indicate the level of assistance he required for transfers, bed mobility, bathing, dressing, toileting, eating, or his physician's ordered diet. 2. Review of resident 59's closed EMR revealed she was admitted to the facility on 1/6/26. There was a signed paper copy of her baseline care plan. It was signed by resident 59's resident representative to indicate that they had received a copy and that it was reviewed with them. It was not dated when it was signed. The last revisions made to the printed baseline care plan were made on 1/9/26. Resident 59's baseline care plan did not indicate the level of assistance she required for transfers, bed mobility, bathing, dressing, toileting, or eating. 3. Review of resident 7's EMR revealed he was admitted to the facility on 9/29/25 and he did not have a baseline care plan. 4. Review of resident 33's EMR revealed she was admitted to the facility on 12/4/25. Her baseline care plan was signed by her representative. There was no date when it was signed. Her baseline care plan was uploaded into her EMR on 12/19/25. Her baseline care plan did not indicate how the resident transferred, walked, if assistive devices were required, or the amount of assistance resident 33 required for dressing or toileting. 5. Review of resident 2's EMR revealed she was admitted to the facility on 2/16/26. There was no baseline care plan in her EMR. 6. Review of resident 40's EMR revealed she was admitted to the facility on 4/3/26. Her 4/5/26 base line care plan did not indicate how she transferred from one surface to another, her diet, or the specific rehabilitation therapies that were ordered by her physician. 7. Interview on 4/27/26 at 4:20 p.m. with regional nurse consultant C revealed residents 2 and 7 did not have individualized baseline care plans	F0655		

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F0655 SS = E	Continued from page 62 completed. 8. Interview on 4/28/26 at 2:46 p.m. with licensed practical nurse (LPN) N revealed that the nurses initiated the baseline care plans for each resident during the admission process. All the nurses and the leadership staff could make changes to the residents' care plans. The care plans should accurately reflect the current needs of each resident. 9. Interview on 4/28/26 at 2:09 p.m. with minimum data set/registered nurse (MDS/RN) H revealed that the staff "probably really do not know" how to provide care if the care plans were not resident-specific and completed. MDS/RN H revealed that she expected the baseline care plan to include information that direct caregivers needed to provide care to the resident. The baseline care plan was shared with the family and or the resident's representative when they had a care conference, and if they were unable to attend, they were to notify MDS/RN H, who would review it with them within 48 hours of the resident's admission. MDS/RN H expected the care plans to be accurate and to reflect the resident's current needs. She confirmed that resident 4 and resident 59's baseline care plans were reviewed with their representatives, but were not personalized to contain specific information on how to care for the residents. She expected that resident 4 and resident 59's baseline care plans would have been personalized to reflect their care needs before they were reviewed with the residents or their representatives. 10. Interview on 4/29/26 at 10:50 a.m. RNC C revealed that she did not think the facility had any signed baseline care plans to provide or documentation that a copy was provided to the resident or resident's representative. 11. Review of the provider's 5/14/25 Care Plans policy revealed: "A Baseline Care plan is started by nursing staff on the first day of admission to provide guidance to direct caregivers as soon as possible after admission and completed no later than 48 hours after admission. Nursing, Dietary, Activities and Social Services staff complete formal assessments, interviews and observation and begin formulating the full care plan as soon after admission as possible (These departments do have areas that need to be completed by the 48-hour	F0655		

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F0655 SS = E	Continued from page 63 deadline)." "The areas that must be addressed in the baseline care plan include the minimum healthcare information necessary to properly care for the resident including, but not limited to: a) Initial goals based on admission orders. b) Physician orders. c) Dietary orders. d) Therapy services. e) Social Services. f) PASARR recommendations, if applicable."	F0655		
F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was reviewed and revised to reflect the current care needs for four of nineteen sampled residents (13, 33, 38, and 40).	F0657	1. Resident care plans for Residents #13, #33, #38, and #40 were reviewed and revised to accurately reflect current resident needs, diagnoses, physician orders, psychotropic medication use, behaviors, interventions, dietary needs, transfer status, rehabilitation services, and applicable risk areas. All residents were identified as having the potential to be affected by the deficient practice. A facility-wide audit of current resident care plans was completed to verify psychotropic medications and target symptoms were care planned, behavioral interventions and non-pharmacological approaches were identified, focus areas were current and resident-specific, inaccurate or resolved focus areas were removed timely, and transfer status, dietary needs, therapy services, and assistance levels were current. Any deficient findings identified during the audit process were corrected immediately. 2. The facility assigned the list of rooms to nurse managers for duties to include timely care planning is completed with pertinent information. DON or designee educated IDT regarding care plan policy requirements, timely updates, and resident-specific interventions by 6/2/2026. Staff not in attendance will receive education on their next scheduled shift. Weekly interdisciplinary care plan review meetings were implemented for residents with significant changes, new orders, psychotropic medication changes, falls, behaviors, or hospital returns. Nursing leadership review of psychotropic medication orders and utilization of a care plan audit tool were implemented to ensure care plans are updated timely and accurately reflect current resident needs and interventions. 3. DON/designee will audit 5 resident care plans weekly for 4 weeks, then monthly for 2	6/2/2026

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F0657 SS = E	Continued from page 64 Findings include: 1. Review of resident 40's electronic medical record (EMR) revealed she was admitted to the facility on 4/3/26. Her 4/5/26 Brief Interview of Mental Status (BIMS) assessment score was a 9, which indicated his cognition was moderately impaired. Her diagnoses included Diabetes Mellitus (a condition involving disruptions in how the body regulates blood sugar), Parkinson's Disease (a brain disorder that makes it hard for a person to control their body movements), Alzheimer's Disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), Dementia (a group of symptoms affecting memory, thinking, and social abilities), Major Depressive Disorder, anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and orthostatic hypotension (a sudden drop in blood pressure that happens when you stand up too quickly from sitting or lying down). Resident 40's 4/5/26 care plan revealed that it did not indicate how she transferred from one surface to another, her diet, and the specific rehabilitation therapies that were ordered by her physician. 2. Review of resident 33's EMR revealed she was admitted to the facility on 12/4/25. Her 3/26/26 BIMS assessment score was 13, which indicated her cognition was intact. Her diagnoses included depression. She had a 3/29/26 physician's order for olanzapine (an antipsychotic medication) 5 milligrams (mg) daily to be administered at bedtime. There was no diagnosis identified on the physician's order that indicated why olanzapine was prescribed. The indication for use was "behaviors and poor mood". She had a 12/4/25 physician's order for sertraline (an antidepressant medication) 100 mg every day to be administered at bedtime for depression. Review of resident 33's progress notes from 3/25/26 to 4/20/26 revealed a 3/25/26 progress note stated, "Becomes very agitated and combative with attempts to assist resident. Grabs [the] staff, kicks, hits, scratches, and pinches. 'You just get out of here! I don't trust any of you!' Mimics sarcastically what [the] staff are asking/saying to her." A 3/28/26 progress note stated, "Resident taking papers off nurse [nurses'] desk and ripping them apart. Yelling and name calling to [the] nurse and other staff." A 3/29/26 progress note stated "Resident is name calling to [the] staff, arguing with [the] staff. Reaching out to pinch another resident." A 4/13/26 progress note stated, "yelling at [the] staff to 'go to hell,' 'don't look at me.' 'you're all evil.'	F0657	additional months, to ensure care plans are updated timely, reflect current psychotropic medication use and behaviors, include non-pharmacological interventions, and remove outdated or inaccurate information. Audit findings will be reviewed monthly in QAPI meeting for further recommendations and ongoing compliance.	

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F0657 SS = E	Continued from page 65 Unable to redirect [the resident]. Resident spit at [the] writer." Review of resident 33's 4/22/26 care plan revealed she had a focus area of "Resident has potential for bruising, hemorrhage due to anticoagulant use", she had not taken an anticoagulant since 3/13/26. Her care plan did not indicate she was on an antipsychotic medication, that she had behaviors, or any nonpharmacological interventions that may be used when she had behaviors. The use of a psychotropic (antidepressant) medication was only identified in resident 33's care plan within the focus area related to her risk of falling. It did not indicate target symptoms for the use of her sertraline or non-pharmacological interventions. 3. Review of resident 13's EMR revealed she was admitted to the facility on 1/15/25. Her current BIMS assessment score was 11, which indicated her cognition was moderately impaired. Her Diagnoses included chronic diastolic heart failure (chronic progressive condition where the heart muscle is too weak to pump blood effectively), paroxysmal atrial fibrillation (irregular rapid heart rate). She had a 1/16/25 physician's order for Clopidogrel (an antiplatelet medication) 75 milligrams (mg) 1 tablet to be administered by mouth (PO) daily. She had a 8/8/25 physician's order for Aspirin (pain medication) 81mg enteric coated (EC) tablet to be administered PO once daily. Her 4/29/26 care plan included a focus area of "potential for bruising, hemorrhage due to anticoagulant use initiated on 1/17/25, and revised on 9/30/25." 4. Review of resident 38's EMR revealed she was admitted to the facility on 4/1/26. Her current BIMS assessment score was 9, which indicated her cognition was moderately impaired. Her diagnoses included atherosclerotic heart disease (a condition where plaque builds up in the heart arteries decreasing blood flow). She had a 4/1/26 physician's order for Aspirin (pain medication) 81 mg EC tablet to be administered PO once daily. She had no anticoagulant (blood thinner) medication ordered. Her current care plan included a focus area of: "I have potential for bruising, hemorrhage due to anticoagulant use and self-propelling in w/c [wheelchair] initiated on 4/1/26 and revision on 4/8/26. 5. Interview on 4/21/26 at 1:36 p.m. with CNA O revealed she referred to the facility's pocket care plan and the Kardex (a report of the resident's care	F0657		

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F0657 SS = E	Continued from page 66 needs and interventions) to determine what care she needed to provide for each resident. She stated there have been times when the packet care plans were not up to date so she referenced the residents' Kardex and notified the nurse that the pocket care plan needed to be updated. 6. Interview on 4/22/26 at 3:22 p.m. with certified nursing assistant (CNA) S revealed she referenced the residents' care plans in their EMR or on the pocket care plans (a document that identifies residents' care needs and interventions) to know how to care for each resident. 7. Interview on 4/28/26 at 2:09 p.m. with minimum data set/registered nurse (MDS/RN) H revealed she started her position as the MDS/RN in September of 2025. She thought that the staff "probably really do not know" how to provide care if the care plans were not resident-specific and completed. She expected care plans to be updated to the resident's current care needs. Care plans were updated at least every three months. They also did a weekly care plan meeting where a set of residents who had upcoming care plan reviews or residents who had a change in status were reviewed to ensure that the focus areas in the care plan were specific to the residents. She was responsible for updating the nursing portion of resident care plans. If a resident was taking an antipsychotic medication, she expected that to be on their care plan as well as interventions to help alleviate their behaviors. Director of nursing (DON) B, assistant director of nursing (ADON) G, and she were responsible for updating the nursing portion of the resident care plans. She confirmed residents 13 and 38 were never on an anticoagulant medication and that their care plans needed to be updated. MDS/RN H updated resident care plans at least quarterly and as needed. She expected the resident care plan to be accurate and to reflect the residents' current needs. 8. Interview on 4/28/26 at 2:46 p.m. with licensed practical nurse (LPN) N revealed the nurses initiated the residents' care plans during the admission process. All the nurses and the leadership staff could update the residents' care plans. The care plans should be updated to accurately reflect the current needs of each resident. Resident 33 had intermittent behaviors such as being rude, abrupt, and blunt to the staff and other residents. LPN N thought the CNAs experienced resident 33's behaviors during her cares more than the nurses witnessed them. LPN N acknowledged that resident 33's behaviors as well as non-pharmacological	F0657		

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F0657 SS = E	Continued from page 67 interventions should be identified in her care plan. 9. Review of the provider's 4/28/25 Psychotropic Medications policy revealed, "Psychotropic medications will be used only when it is necessary to treat a specific condition after non-pharmacological interventions have been attempted to assist with residents displaying mood, behavior, or sleep concerns." "Resident's receiving psychotropic medication will have adverse side effects and target behaviors addressed in the care plan and will be monitored, recorded, and summarized each quarter." 10. Review of the provider's revised 5/14/25 Care Plans policy revealed "Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team through the resident's stay to promote optimal quality of life while in residence. In doing so, the following considerations are made: 1. Each resident is an individual. The personal history, habits, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical/diagnosis-based care considerations. 2. Each resident has the right to be happy, continue their life-patters as able, and feel comfortable in their surroundings. 3. Care planning is constantly in process; it begins the moment the resident is admitted to the facility and doesn't end until discharge or death. 4. Each resident is included in the care planning process and encouraged to achieve or maintain their highest practicable physical and mental abilities through the nursing home stay. 5. The physician's orders (including medications, treatments, labs, and diagnostics) in conjunction with the resident's plan constitute the total 'plan of care'. Physician orders are referenced in the resident's care plan, but not rewritten into that care plan."	F0657		
F0695 SS = E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this	F0695	1. Resident #1's oxygen tubing and nasal cannula were immediately discarded and replaced after observation of the nasal cannula touching the floor. A mesh storage bag was placed on the oxygen concentrator. Residents #2 and #48's nebulizer equipment was immediately cleaned, disinfected, and properly stored according to facility policy and manufacturer recommendations. Oxygen tubing and nasal cannulas for Resident #48 were replaced and appropriate storage bags added.	6/2/2026

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F0695 SS = E	Continued from page 68 subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview and policy review the provider failed to ensure infection control practices were followed regarding the residents' nasal cannulas (flexible tubing with prongs that delivers oxygen through the nose) being stored properly when they were not in use for one of three sampled residents (1) who required the use of oxygen, and two of three sampled resident (2, and 48) who used a nebulizer (a device that converts liquid medication into an inhalable mist) machine that was not cleaned after each use by the nursing staff and per their policy. Findings include: 1. Observation on 4/21/26 at 9:23 a.m. of resident 1's room revealed her oxygen concentrator was off and her dated 4/7/26 (two weeks prior) nasal cannula and tubing was draped over the concentrator, and the nasal cannula was touching the floor. There was no bag attached to the concentrator to store the oxygen tubing when not in use. 2. Observation on 4/27/26 at 11:02 a.m. of resident 1's room revealed her dated 4/7/26 (three weeks prior) oxygen tubing and nasal cannula hanging over the concentrator and the nasal cannula was lying on the floor. 3. Interview on 4/27/26 at 11:55 a.m. with certified nursing assistant (CNA) HH revealed that resident 1 only wears her oxygen at night. She agreed the nasal cannula should not touch the floor. She confirmed there was no bag on the concentrator to contain the nasal cannula and tubing when not in use. She removed the nasal cannula and tubing from the concentrator and threw them away. She agreed it was an infection control issue. 4. Interview on 4/27/26 at 11:58 a.m. with licensed practical nurse (LPN) N revealed that nasal cannulas and oxygen tubing should be stored in a mesh bag when not in use. 5. Interview on 4/28/26 at 3:26 p.m. with director of nursing (DON) B revealed she expects oxygen tubing to be placed in mesh bags that are on the concentrators, for continuous users the tubing and nasal cannulas were switched between portable tanks and concentrators. She agreed that if the nasal cannula and tubing was observed on the floor they	F0695	All residents were identified as having the potential to be affected by the deficient practice. A facility-wide audit was completed for residents receiving oxygen therapy, nebulizer treatments, or respiratory equipment use to ensure oxygen tubing and nasal cannulas were stored appropriately off the floor, storage bags were available and in use, nebulizer equipment was clean and dry, and respiratory supplies were dated and changed per policy. Any deficient findings identified during the audit process were corrected immediately. 2. Respiratory equipment storage bags were ordered and implemented to ensure proper storage of oxygen tubing and respiratory supplies. DON or designee educated all nursing staff regarding oxygen and nebulizer equipment cleaning, storage, dating requirements, and infection control practices by 6/2/2026. Staff not in attendance will receive education on their next scheduled shift. 3. DON/designee will audit 5 residents weekly for 4 weeks, then monthly for 2 additional months, to ensure oxygen tubing is stored appropriately in mesh or plastic bags, supplies are dated per policy, and nebulizer equipment is cleaned and stored appropriately after use. Audit findings will be reviewed monthly in QAPI meeting for further recommendations and ongoing compliance.	

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F0695 SS = E	Continued from page 69 should be thrown away and replaced. After nebulizer treatments are administered the nurse needs to take apart the pieces of the kit, rinse them out, and place them to air dry before their next use. Nebulizer kits, oxygen tubing, and nasal cannula are replaced weekly. 6. Review of the provider's revised 11/18/25 Oxygen Administration policy revealed "the purpose of this procedure is to provide guidelines for oxygen administration. b. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. The nasal cannula and tubing will be changed weekly and as needed. Change of tubing and cannula should be documented. When not in use, the nasal cannula should be stored in a plastic bag." 7. Observation on 4/21/26 at 8:30 a.m. of resident 2's room revealed she had a nebulizer machine and mask on her over the bed table. The medication chamber had a clear liquid covering the bottom of the chamber. 8. Observation and interview on 4/21/26 at 10:52 a.m. with resident 2 in her room revealed the nurse would bring in her nebulizer medication, set up the nebulizer and leave the room. She stated the nurses did not rinse out her nebulizer mask after she used it but replaced the mask every few days. 9. Observation on 4/28/26 at 9:42 a.m. of resident 2's room revealed her assembled nebulizer mask was lying on her nebulizer machine and the medication chamber had a hazy film on the inside of the chamber. 10. Review of resident 2's EMR revealed she was admitted to the facility on 2/16/26. Her BIMS assessment score was 15, which indicated her cognition was intact. Her diagnoses included chronic obstructive pulmonary disease (COPD; a group of lung diseases that block airflow and can make it difficult to breathe). She had a 2/16/26 physician's order for budesonide suspension (a steroid used to treat lung inflammation) to be administered through her nebulizer two times a day for COPD, Formoterol (a medication to relax the airways to improve breathing) to be administered through her nebulizer two times a day for COPD, ipratropium/albuterol (medication to relax the airways and decrease mucous) nebulizer to	F0695		

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F0695 SS = E	Continued from page 70 be administered every four hours as needed for difficulty breathing. 11. Observation on 4/21/26 at 8:42 a.m. of resident 48's room revealed he had an assembled nebulizer mask lying on his bedside table. There was no bag near his nebulizer to store his nebulizer when it was not in use. There was a nasal cannula attached to his oxygen concentrator (a device that filters room air into purified oxygen). The nasal cannula was coiled up and stuffed under the handle of the oxygen concentrator. There was no bag attached to the concentrator to store the nasal cannula when it was not being used. 12. Observation and interview on 4/22/26 at 10:16 a.m. with resident 48 in his room revealed his nasal cannula was draped over the oxygen concentrator with the nasal prongs nearly touching the floor. He wore oxygen at night. The staff assisted him with putting on and taking off his nasal cannula because he was blind and could not do it by himself. 13. Observation on 4/27/26 at 11:05 a.m. of resident 48's room revealed that his nebulizer mask was assembled and lying on top of his bedside table. His oxygen cannula was rolled up and stuffed under the handle of his oxygen concentrator. 14. Review of resident 48's EMR revealed he was admitted to the facility on 4/26/22. His 3/13/26 BIMS assessment score was 15, which indicated he was cognitively intact. His diagnoses included that he was legally blind and had COPD. He had a 4/27/22 physician's order to use one to two liters of oxygen as needed to keep his oxygen saturations above 90 percent. He had a 2/29/25 physician's order for ipratropium/albuterol solution to be administered by nebulizer every six hours while he was awake. 15. Interview and review of resident 2's EMR on 4/28/26 at 2:31 p.m. with LPN N revealed she would set up resident 2's nebulizer treatment, and when it was completed resident 2 would remove the mask, turn off the nebulizer machine, and place her nebulizer mask on top of her nebulizer machine. Sometime between resident 2's nebulizer treatments LPN N would go back into resident's room and rinse out the nebulizer mask and air dry the mask on a paper towel until the next nebulizer treatment was	F0695		

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F0695 SS = E	Continued from page 71 administered. 16. Review of the provider's January 2018 Oral Inhalation policy revealed, "When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup." "Rinse and disinfect the nebulizer equipment according to manufacturer's recommendation, or: Wash pieces except tubing with warm soapy water daily. Rinse with hot water. Allow to air dry completely on a paper towel. Once a week/three times a week/daily, disinfect the equipment by using a Microsteam bag in the microwave for time recommended on bar, OR Soaking for 5 minutes in 70 % [percent] isopropyl alcohol and then rinse with sterile water." "When equipment is completely dry, store in a plastic bag with the resident's name and date on it." 17. Review of the 2/13/23 budesonide manufacturer's instructions revealed "The nebulizer chamber should be cleaned after every administration. Wash the nebulizer chamber and mouthpiece of face mask with hot tap water using a mild detergent. Rinse it well and dry by connecting the nebulizer chamber to the compressor or air inlet."	F0695		
F0700 SS = E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F0700	1. Residents identified with deficient mobility bar documentation, assessments, physician orders, consents, alternative intervention documentation, and entrapment assessments had records reviewed and corrected as indicated. Physician orders, consents, side rail/device evaluations, alternative interventions, entrapment zone assessments, and care plan documentation were reviewed and updated for Residents #2, #3, #4, #8, #12, #14, #15, #16, #17, #19, #22, #23, #24, #25, #27, #29, #31, #32, #33, #35, #36, #37, #45, #47, and #48. Loose mobility bars, mattress gaps, missing assessments, and missing documentation identified during the review process were corrected immediately. All residents with bed rails are at risk for deficient practice. Maintenance completed a 100% audit of all beds with mobility bars was completed on 4/23/26. Audits included: verification of secure side mobility bar installation, measurement of all applicable entrapment zones, inspection of mattress fit and stabilization, verification that mattress stabilizers and hardware were present	6/2/2026

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F0700 SS = E	Continued from page 72 §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, interview, and policy review, the provider failed to ensure informed consents for side rails were obtained before the side rails were installed for seven of 25 sampled resident (4, 15, 16, 23, 25, 32, and 36), physician's orders, in accordance with the provider's policy, were obtained before side rails were installed for 12 of 25 sampled residents (2, 3, 4, 8, 15, 16, 17, 19, 29, 32, 36, and 45), alternatives to the side rails were attempted before the side rails were installed for 21 of 25 sampled residents (3, 4, 8, 15, 16, 17, 19, 22, 23, 24, 25, 27, 29, 31, 33, 35, 36, 37, 45, 47, and 48), and entrapment zone assessments were completed on 23 of 25 sampled resident (2, 3, 4, 8, 12, 14, 15, 16, 17, 19, 22, 23, 24, 27, 31, 32, 33, 35, 36, 37, 45, 47, and 48) who had side rails on their bed. Findings include: 1. Review of the maintenance logbook for side rail inspections for January 2026 through April 2026 revealed in January the side rail audits documented that zone 1 (the opening within the side rail) was the only entrapment zone assessed. The other six zones of entrapment were documented as "not applicable". In February all seven zones of entrapment were documented as having "passed" the audit on every bed assessed. In March only zone 1 was documented as being assessed, all the other six zones were documented as "not applicable". In April six side rail assessments were documented as "passed" for zone one with "not applicable" for the other 6 zones. Twenty-one side rail audits were documented as "not applicable" for all seven zones. Those residents documented as not applicable for all seven entrapment zones in April 2026 included residents 2, 3, 4, 12, 14, 16, 17, 22, 23, 31, 33, 35, 36, 37, 45, 47, and 48. Resident identified as having side rails that were not on the April 2026 side rail audit included residents 8, 27, and 32. There were no entrapment assessments for zone 7 (space between a mattress and headboard or footboard) from January 2026 through April 2026 documented for residents without a bed rail. Residents 15, 19, and 24 had side rails installed, but maintenance did not have record of the side rails for	F0700	and intact. IDT completed a review of physician orders, consents, and assessments related to mobility bar use. Any identified concerns were corrected immediately through repair, replacement, removal, or adjustment of equipment. 2. The facility replaced identified mobility bars with newly purchased equipment and reinforced inspection processes to ensure proper bed system safety. On 4/23/26, all staff minus dietary were educated by the RNC to verify appropriate mattress fit and stabilization, confirm mattress stabilizers are present and intact, and ensure all mobility bar hardware is properly installed and secure. Ongoing inspections were implemented to verify bed components remain properly fitted, stabilized, and free from conditions that could create entrapment or injury risks. Beginning 5/13/2026, all staff were re-educated by the Administrator or designee regarding FDA entrapment guidance, proper installation and tightening of side rails and mobility bars, accurate entrapment zone measurements, mattress stabilization requirements, documentation expectations, immediate reporting and correction of unsafe gaps or loose equipment, side rail consents, physician orders, and assessments were reviewed for accuracy and completeness. Staff who were not in attendance will receive education on their next scheduled shift. Maintenance audit tools were revised to clearly identify all applicable entrapment zones and prohibit use of "not applicable" unless clinically appropriate. 3. Administrator/designee will audit 5 residents with mobility bars weekly for 4 weeks, then monthly for two additional months. Administrator or designee will present audit findings monthly in QAPI meeting for progress review and further recommendations.	

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F0700 SS = E	Continued from page 73 these residents. 2. Observation on 4/21/26 at 8:30 a.m. of resident 2's room revealed she had bilateral side rail on her bed. The opening within the sides rail measured three and one- half inches in width by 12 inches in height from the mattress to the top of the opening. Review of resident 2's electronic medical record (EMR) revealed she was admitted to the facility on 2/16/26. She consented to the use of bilateral side rails for positioning and bed mobility on 2/16/26. There was a 2/17/26 physician's order for side rails. Her 2/17/26 Side rail/Devices Evaluation indicated the alternative attempted before the implementation of her side rails was "Directed/supervised ambulation." Review of the maintenance record revealed resident 2's bilateral side rails were installed on 2/16/26. 3. Observation on 4/22/26 at 3:25 p.m. of resident 45's side rails revealed she had bilateral side rails on her bed and the opening within her side rails measured three and one-half inches in width and 11 inches in height. Review of resident 45's EMR revealed she admitted to the facility on 4/22/22. She signed a consent for "1/4" on 4/22/22. There was no physician's order for side rails. The Side rail/Other Devices Evaluation was completed on 6/24/22 for bilateral side rails. There were no documented alternatives attempted prior to the implementation of the side rail. Review of the maintenance record revealed resident 45's bilateral side rails were installed on 4/20/22, before her admission date. 4. Observation on 4/21/26 at 8:36 a.m. of resident 14's room revealed she had one side rail on her bed. Review of resident 14's EMR revealed she was admitted to the facility on 7/22/25. A side rail consent was completed on 7/22/25 for a left side rail. There was a 7/22/25 physician's order for a left side rail. Resident 14's Side rail/Other Devices Evaluation was completed on 10/14/25. Alternatives that had been attempted were increased involvement in structured programming activities, psychotropic medication review, physical/occupational therapy screen, and restorative nursing program screen.	F0700		

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F0700 SS = E	Continued from page 74 Review of the maintenance record revealed resident 14 did not have side rails installed. 5. Observation on 4/22/26 at 4:30 p.m. of resident 17's bilateral side rails revealed two openings within the side rail. The top opening measured four and three-quarters inches in width by five and one-half inches in height. The bottom opening measured four and three-quarters inches in width by four and one-half inches in height. Review of resident 17's EMR revealed she was admitted to the facility on 12/16/21. She did not have a physician's order or consent for her bilateral side rails. Her 9/10/25 Side rail/Other Devices Evaluation indicated that the alternatives attempted before the implementation of the side rails were "mobility bars [side rails]" Review of the maintenance record revealed resident 17's bilateral side rails were installed on 4/24/26. 6. Observation and interview on 4/22/26 at 10:31 a.m. with resident 35 in his room revealed his bilateral side rails moved away from his bed one to two inches. He stated they had been like that since he admitted to the facility. Observation on 4/22/26 at 3:27 p.m. of resident 35's bed revealed there was a gap of five inches between the top of his mattress and the headboard. The top opening of his bilateral side rails measured four and three-quarter inches in width by five and one-half inches in height. The bottom opening measured four and three-quarters inches in width by four and one-half inches in height. Review of resident 35's EMR revealed he was admitted to the facility on 11/5/25. His consent for a right-side rail was completed on 11/5/25. He had an 11/5/25 physician's order for a right-side side rail. His Side Rail/Other Device evaluation was completed on 2/9/26 and indicated he had bilateral side rails. The alternatives that were implemented was documented as "Other" and not listed. Review of the maintenance record revealed resident 35's bilateral side rails were installed on 4/23/26. 7. Observation on 4/21/26 at 8:42 a.m. of resident 48's room revealed he had bilateral side rails on his bed.	F0700		

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F0700 SS = E	Continued from page 75 Observation and interview on 4/22/26 at 10:16 a.m. with resident 48 in his room revealed he had bilateral side rails on his bed. He used the left side rail to get in and out of bed, but it was loose. He did not use the right-side rail because it was against the wall. He thought the side rails were on his bed because he had nightmares which made him move around in bed and he had fallen out of his bed due to the nightmares. His left side rail could move away from the mattress three inches when pulled. He denied that he had gotten a body part stuck in either side rail. He had told a certified nursing assistant (CNA) and his daughter that his left side rail was loose but did not know when he told them. He thought it had been a week or so. Observation on 4/22/26 at 3:27 p.m. of resident 48's side rails revealed the opening within the side rail measured three and one-half inches wide by 11 inches in height. Review of resident 48's electronic medical record (EMR) revealed he was admitted to the facility on 4/26/22. He had a 3/13/26 Brief Interview of Mental Status (BIMS) assessment score of 15, which indicated his cognition was intact. His diagnoses included that he was legally blind. On 8/15/25 he had a dream and fell out of his bed. He was sent to the emergency room after that fall and was diagnosed with a brain bleed (a vessel or around the brain busts causing blood to pool in the skull). Resident 48 had a 4/26/22 consent and physician's order for bilateral side rails. He had a 4/26/22 and 8/20/25 Side rail/Other Device Evaluation that did not identify alternatives were attempted before the implementation of the side rails. Review of the maintenance record revealed resident 48's bilateral side rails were installed on 4/26/22. 8. Observation on 4/21/26 at 8:55 a.m. of resident 25 revealed she had bilateral side rails on her bed. Review of resident 25's EMR revealed she was admitted to the facility on 1/10/25. Her 1/20/25 side rail consent had her initials on it, but it did not indicate if she consented or refused bilateral side rails. She had a 1/17/25 physician's order for bilateral side rails and her Side rail/Other Devices Evaluation was completed on 10/14/25, nine months after the side rail was installed on her bed. Review of the maintenance record revealed resident	F0700		

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F0700 SS = E	Continued from page 76 25's bilateral side rails were installed on 1/17/25. 9. Observation on 4/21/26 at 9:31 a.m. of resident 8's room revealed she had bilateral side rails on her bed. Review of resident 8's EMR revealed she had a 10/17/23 consent for bilateral side rails and a 12/23/24 physician's order for bilateral side rails. Her 2/12/26 Side rail/Other Devices evaluation indicated she did not have side rails. Review of the maintenance record revealed resident 8's bilateral side rails were installed on 10/17/23. 10. Observation and interview on 4/21/26 at 10:04 a.m. of resident 33's room revealed she had bilateral side rais on her bed and she uses them to get out of bed. The opening within the side rails measured three and one-quarter inches wide by 14 inches in height from the top of the mattress to the top of the opening within the side rail and 17 inches from the bed frame to the top of the opening in the side rail. Review of resident 33's EMR revealed she was admitted to the facility on 12/4/25. She had a 12/4/25 physician's order and the consent for bilateral side rails. Her 12/4/25 Side rail/Other Devices Evaluation indicated she did not have side rails. Review of the maintenance record revealed resident 33's bilateral side rails were installed on 12/4/25. 11. Observation on 4/21/26 at 10:10 a.m. of resident 15's room revealed she had a left side rail on her bed. Review of resident 15's EMR revealed she was admitted to the facility on 7/11/25. On 7/11/25 a consent for bilateral side rails was signed. On 7/11/25 a physician's order was received for bilateral side rails. Her Side rail/Other Devices Evaluation was not completed until 10/13/25, three months after she consented for the side rails. Review of the maintenance record revealed resident 15's did not have side rails installed. 12. Observation on 4/21/26 at 10:12 a.m. of resident 24's room revealed she had a left side rail.	F0700		

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F0700 SS = E	Continued from page 77 Review of resident 24's EMR revealed she was admitted to the facility on 3/18/26. She had a signed consent for a left side rail on 3/18/26. The 3/19/26 physician's order did not include a specific side or if there was to be bilateral side rails installed. There was no completed Side rail/Other Device Evaluation completed. Review of the maintenance record revealed resident 24's did not have a side rail installed. 13. Observation on 4/21/26 at 10:23 a.m. of resident 36's room revealed she had one side rail on her bed. Review of resident 36's EMR revealed she was admitted to the facility on 4/1/26. There was no consent, or physician's order for side rails. Her Side rail/Other Devices Evaluation was not been completed. Review of the maintenance record revealed resident 36's bilateral side rails were installed on 4/1/26. 14. Observation on 4/21/26 at 10:29 a.m. of resident 23's room revealed she had bilateral side rails. Observation and interview on 4/22/26 at 10:36 a.m. with resident 23 in her room revealed she used the side rails to roll over in bed. The right-side rail moves away from the bed two to three inches. Resident 23 did not know how long her side rail had been loose. The opening within the side rails measured three and one-half inches wide by 13 inches in height. The space between the foot of her mattress and the foot board was seven inches. Review of resident 23's EMR revealed she was admitted to the facility on 12/17/21. A physician's order was received for bilateral side rails on 12/17/21. A consent was signed for bilateral side rails on 12/17/25. The Side rail/Other Devices Evaluation for bilateral side rails were completed on 3/21/22, 6/21/22, 11/5/25, and 2/5/26 and did not indicate that any alternative interventions were attempted before the side rails were installed. Review of the maintenance record revealed resident 23's "left" side rail was installed on 4/23/26. 15. Observation on 4/21/26 at 10:33 a.m. of resident 31's room revealed she had bilateral side rails on her bed.	F0700		

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F0700 SS = E	Continued from page 78 Review of resident 31's EMR revealed she was admitted to the facility on 8/4/25. She consented to bilateral side rails on 8/4/25. A physician's order for bilateral side rails was obtained on 8/5/25. Her Siderail/Other Device Evaluation was not completed until 10/13/25. Review of the maintenance record revealed resident 31's bilateral side rails were installed on 8/4/25. 16. Observation on 4/21/26 at 10:35 a.m. of resident 37's room revealed he had one side rail on his bed. Review of resident 37's EMR revealed he was admitted to the facility on 5/13/25. A consent for a right-side rail was signed on 5/12/25, prior to her admission to the facility. There was a 5/14/25 physician's order for a right-side rail. Her Side rail/Other Devices Evaluation was not completed until 10/14/25. Review of the maintenance record revealed resident 37's right side rail was installed on 8/4/25. 17. Observation on 4/21/26 at 11:10 a.m. of resident 19's room revealed she had bilateral side rails on her bed. Review of resident 19's EMR revealed she was admitted to the facility on 3/7/23. A consent for bilateral side rails was signed on 10/20/25. There was no physician's order for side rails. There were no Side rail/Other Device Evaluations completed. Review of the maintenance record revealed resident 19 did not have side rails installed. 18. Observation and interview on 4/22/26 at 6:25 p.m. with licensed practical nurse (LPN) N in resident 32's revealed resident 32 had a side rail on the right side of her bed. LPN N determined if a side rail or mattress was a risk for entrapment for a resident if there was a gap that a body part could be trapped in. LPN N measured the space at the top of the mattress to the side rail and the bottom of the mattress to the side rail when she assessed for an entrapment. She centered the mattress on the bed when she took the measurement even if the mattress could be slid over. Resident 32's mattress was able to slide to the wall leaving an eight-inch gap between the mattress and the side rail.	F0700		

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F0700 SS = E	Continued from page 79 Review of resident 32's EMR revealed she was admitted to the facility on 2/4/26. Resident 32's representative declined the installation of side rails on 2/4/26. Review of the maintenance record revealed that resident 32 did not have a side rail installed. 19. Review of resident 3's EMR revealed he was admitted to the facility on 6/22/23. He consented for bilateral side rails on 6/22/23. A physician's order was obtained for bilateral side rails on 6/23/23, after the bed rails had been installed. His Side rail/Other Device Evaluation was completed on 4/6/26, three years after the side rails were installed. Review of the maintenance record revealed resident 3's bilateral side rails were installed on 6/22/23. 20. Review of resident 47's EMR revealed she was admitted to the facility on 10/25/24. She signed a consent for bilateral side rails on 10/25/24. On 10/28/24 a physician's order for bilateral side rails was received. Her 8/30/25 Side rail/Other Devices Evaluation documented alternatives attempted before the implementation of her side rails was "mobility bars". Review of the maintenance record revealed resident 47's bilateral side rails were installed on 10/25/25. 21. Review of resident 12's EMR revealed he was admitted to the facility on 10/8/24. He had a 10/8/24 physician's order for bilateral side rails. There was a consent signed on 10/8/24 for bilateral side rails and on 1/21/25 for a left side rail. His care plan indicated he had a left side rail that was initiated on 10/23/24 and revised on 10/21/25. There was no Side rail/Other Devices Evaluation completed for his side rails. Review of the maintenance record revealed resident 12's left side rail was installed on 4/23/26. 22. Review of resident 16's EMR revealed she was admitted to the facility on 10/29/24. There was a consent signed for bilateral side rails on 12/5/24. The physician's order for bilateral side rails was obtained on 10/30/24, after the side rails had been installed. Her Side rail/Other Devices Evaluation was not completed until 10/14/25.	F0700		

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F0700 SS = E	Continued from page 80 Review of the maintenance record revealed resident 16's bilateral side rails were installed on 10/29/24. 23. Review of resident 22's EMR revealed he was admitted to the facility on 4/3/25. A consent was signed for bilateral side rails on 4/3/25. A physician's order for the bilateral side rails was obtained on 4/4/25. His 10/8/25 Side rail/Other Devices Evaluation indicated the alternative attempted before the implementation of the side rails was "Other" with nothing else documented. Review of the maintenance record revealed resident 22's bilateral side rails were installed on 4/3/25. 24. Review of resident 4's EMR revealed he was admitted to the facility on 9/25/25. The consent for bilateral side rails was completed on 10/20/25, twenty days after the side rail had been installed. A physician's order for bilateral side rails was obtained, and his Side rail/Other Device Evaluation was completed on 10/15/25, two weeks after the side rails were installed. Review of the maintenance record revealed resident 4's bilateral side rails were installed on 9/30/25. 25. Review of resident 29's EMR revealed he was admitted to the facility on 12/18/25. A consent for bilateral side rails was obtained on 12/18/25. There was a 12/23/25 physician's order for bilateral side rails, five days after the side rail was installed. His Side rail/Other Device Evaluation was completed on 12/19/25, one day after the side rail was installed. Review of the maintenance record revealed resident 29's side rail was installed on 12/18/25. 26. Review of resident 27's EMR revealed she was admitted to the facility on 2/27/26. She consented to a left side rail on 3/13/26. A physician's order for a left side rail was obtained on 3/13/26. Her Side rail/Other Device Evaluation was not completed. Review of the maintenance record revealed resident 27's left side rail was installed on 3/13/26. 27. Interview on 4/22/26 at 6:06 p.m. with director of nursing (DON) B revealed she was unsure if the provider had a policy related to entrapment assessments. She thought maintenance did the	F0700		

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F0700 SS = E	Continued from page 81 entrapment assessments on the residents' beds. The side rail assessments were to be completed by the nurse on the resident's admission if the resident or resident's representative wanted a side rail and quarterly by the Minimum Data Set (MDS) nurse. DON B completed the consent for side rails with the resident or the resident's representative and that consent had the risks versus benefits of a side rail on it. 28. Interview and review of the maintenance logbook for side rail inspections on 4/28/26 at 10:15 a.m. with regional maintenance II revealed when the maintenance staff completed the side rail audits they would first verify with the nurses that the residents still need the side rail on their bed, and if they have a left, right, or bilateral side rails. The maintenance staff would check the side rail to be sure it is tightly secured to the resident's bed, and measured the entrapment zones to be sure they were less than four and three-quarter inches. He expected all seven entrapment zones to be checked but with the style of side rail that was in the facility only three of the zones applied. The side rail audits were to be completed by maintenance monthly. During the side rail audits the mattress was to be measured to be sure there was not a large gap between the mattress and the footboard or headboard. The measurements of the gaps between the mattress and head and footboard as well as the side rails were completed with a tape measure. He was not aware that in March 2026, only entrapment zone one was audited, and all the other zones were documented as "not applicable" or that in April 2026 the side rail audit indicated all seven zones were "not applicable". He expected all entrapment zones to be checked monthly and documented as "passed" or "not applicable". He acknowledged that there were gaps between some residents' mattresses and their head or footboard which posed a risk for entrapment and there were loose side rails on the residents' beds which posed a risk for injury. 29. Interview on 4/29/26 at 9:30 a.m. with administrator A revealed that maintenance staff was responsible for completing monthly audits of the residents' side rails to be sure nothing had changed or been modified since their original installation. The audits of the side rails were documented in the	F0700		

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F0700 SS = E	Continued from page 82 facility's online maintenance system. Administrator A reviewed that system to be sure the side rail audits were completed. If a resident was identified as needing a side rail installed that recommendation was communicated to the family and the resident's physician. The risks and benefits of the side rail, including entrapment, were reviewed with the resident or the resident's family, and representative, and once those steps were completed the maintenance department would install the side rail. The maintenance staff were to ensure the entrapment zone measurements were in compliance with the recommendations from the food and drug administration (FDA). She stated the measurements within the opening of the side rails were to be less than the four and three-quarter inches in width, and the FDA guidance did not address the measurements related to the height of the opening within the side rails. 30. Interview on 4/29/26 at 10:09 a.m. with DON B revealed the consent for side rails was in the admission packet and all residents were offered side rails at the time of their admission. DON B stated she knew that alternate interventions should be attempted before side rails were put on a resident's bed, but she was following the resident's and resident representative's wishes. The physical and occupational therapy staff also recommended side rails for some residents who received therapy to improve their mobility and independence. DON B acknowledged that there was missing documentation related to side rail assessments, consents, and physician orders. She stated there were side rails on residents' beds that were not documented when they were put on. She acknowledged that there was a risk for resident entrapment and injury when entrapment zone measurements and assessments were not completed on side rails and mattresses, and when the side rails were loose. 31. Review of the provider's 11/18/25 Bed Rail policy revealed, "These bars [side rails] pose safety hazards and must be evaluated for appropriate placement for the sole purpose of transfer and bed mobility assistance for the resident." "The Side Rail/Other Devices Evaluation UDA [Universal Design for Assessment] is: a. Completed prior to implementation of a rail by a licensed nurse.	F0700		

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F0700 SS = E	Continued from page 83 b. Completed on admission, readmission, quarterly, or upon change in condition and in conjunction with the RAI [Resident Assessment Instrument] process for each resident using a device." "Physician Orders for Device(s): a. Should not be obtained until the appropriate steps have been completed. B. Should include the type of rail used and how many rails are to be used. c. Should not be obtained until the nurse discusses prior interventions attempted with resident's physician and resident or resident representative. These interventions should be listed on the UDA." "Bed Rails are implemented after addressing the risk and benefits with the resident and/or resident's representative and obtaining the Physical Device Consent." "The Entrapment Zone Review Form (or electrical format in TELS) is completed upon placement of rails, quarterly and with a resident change of condition. Entrapment zones should be assessed with any changes of mattress.	F0700		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the staff educated the resident or resident's representative of the risk versus benefits of medications or of	F0552	1. Resident #33 and Resident #3's psychotropic medication records, physician orders, informed consent forms, diagnoses, care plans, and supporting documentation were reviewed by nursing leadership, pharmacy consultant, and the interdisciplinary team. Documentation was updated as appropriate to ensure the medication indication/diagnosis was identified, risks and benefits were reviewed with the resident and/or representative, alternative treatment options and non-pharmacological interventions were discussed, required consent forms were completed fully and accurately, and care plans reflected psychotropic medication use and monitoring. Residents and/or responsible parties were re-educated regarding the purpose, risks, benefits, and alternatives related to psychotropic medication use. All residents were identified as having the potential to be affected by the deficient practice. The facility implemented an updated form and standardized psychotropic medication review process to ensure required documentation is completed prior to initiation of therapy or dose adjustment. A facility-wide audit was completed for all residents receiving psychotropic medications, including antipsychotics,	6/2/2026

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F0552 SS = D	Continued from page 84 alternative treatments to make an informed decision and consent for the use of psychotropic medications (drugs that affects brain activities associated with mental processes and behavior) before they were given for two of two sampled residents (3 and 33). Findings include: 1. Review of resident 33's electronic medical record (EMR) revealed she was admitted to the facility on 12/4/25. Her 3/26/26 Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact. Her diagnoses included depression. She had a 3/6/26 physician's order quetiapine (an antipsychotic medication; a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions) 25 milligrams (mg) at bedtime that did not have a diagnosis that the medication was prescribed to treat. Her Antipsychotic Medication Consent Form listed "Quetiapine" and was signed and dated by the resident representative and director of nursing (DON) B on 3/20/26. The form indicated the antipsychotic medication was being used for resident 33's "mood". The area on the form where the alternatives to the prescribed medications that "may be used instead of this medication" was blank. The area on the Antipsychotic Medication Consent form labeled, "Check Here if Taking" before each listed antipsychotic medication's warnings, did not have a check mark in front of the warnings for quetiapine. Resident 33 had a 3/29/26 physician's order to stop the quetiapine and start olanzapine (an antipsychotic medication) 5 mg daily at bedtime. There was no diagnosis identified on the physician's order that supported what olanzapine was prescribed for. Her Antipsychotic Medication Consent Form listed "Olanzapine" and was signed and dated by the resident representative and DON B on 3/30/26. The area on the form that indicated what the olanzapine was ordered for was blank. The area on the form where the alternatives to the prescribed medications that "may be used instead of this medication" was blank. The area on the Antipsychotic Medication Consent form that indicated, "Check Here if Taking" before each listed antipsychotic medication's warnings, did not have a check mark in front of the warnings for olanzapine. Her 4/22/26 care plan did not identify that she was taking an antipsychotic medication, that she had an alteration in her mood, or that she displayed any	F0552	antidepressants, anxiolytics, and hypnotics, to ensure physician orders included a diagnosis or clinical indication, informed consent forms were complete, risks, benefits, and alternatives were documented, required black box warnings were reviewed when applicable, care plans accurately reflected psychotropic medication use, and documentation supported resident and/or representative participation in treatment decisions. Any deficient findings identified during the audit process were corrected immediately. Licensed nurses, social services, MDS nurse, and interdisciplinary team members were re-educated regarding resident rights related to informed consent and treatment decisions. 2. The Administrator, DON, and interdisciplinary team, in collaboration with the governing board and medical director, reviewed applicable policies and procedures to ensure residents' rights are protected and honored. Verified policies and procedures addressed processes and expectations for identifying and honoring residents' rights including but not limited to resident' dignity, privacy, and self-determination of choices and preferences, and accommodating those preferences related to bathing process preferences, privacy, and dignity; providing adequate education to residents and/or their representatives for informed decisions regarding consent for treatments such as psychotropic medication use; and maintaining protected health and payor source information privately and confidentially. Education was provided to all staff about their roles and responsibilities regarding those policies, procedures, and processes. Competencies of staff knowledge completed within 30 days upon hire, annually and as needed. 3. DON/designee will audit 5 residents to ensure informed consent forms are fully completed and signed, include the correct medication and corresponding diagnosis, reflect the current physician order, identify the appropriate clinical indication for use, and are supported by corresponding documentation within the medical record and care plan for 4 weeks,	

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F0552 SS = D	Continued from page 85 behaviors. 2. Interview on 4/29/26 at 10:09 a.m. with DON B revealed that she expected all antipsychotic medications to have a diagnosis to indicate what the antipsychotic medication was being used for. If a medication was started after the resident was in the facility, she expected the nurse who received the order to confirm there was a diagnosis for that medication and if there was not, she expected that nurse to call or fax the physician to get the diagnosis for that medication. 3. Review of resident 3's EMR revealed he was admitted to the facility on 6/22/23. His 1/12/26 BIMS assessment score was 15, which indicated his cognition was intact. His diagnoses included major depressive disorder (a serious, common mood disorder characterized by at least two weeks of persistent, severe low mood, loss of interest, and low energy that disrupts daily life, bipolar disorder (a chronic mental health condition characterized by intense, alternating mood swings between highs and lows), current episode manic (high mood) severe with psychotic (a loss of contact with reality) features, schizophrenia (chronic, severe brain disorder affecting how a person thinks, feels, and behaves, causing a disconnection from reality) and insomnia (a sleep disorder characterized by persistent difficulty sleeping). There was a 1/31/25 physician's order for paroxetine (an antidepressant) 10 mg (milligrams) and aripiprazole (an antipsychotic) 15 mg at bedtime. His Psychotropic Medication Consent form listed "Aripiprazole" and "Paroxetine" and was signed and dated by the resident and the facility representative on 2/18/25. There was no documentation of the doses of those medications, the frequency they were to be provided, the diagnosis, or the "targeted behavior". There was no documentation that the risks and/or benefits of those medications were discussed with the resident or his representative. Those areas of the form were left blank. His care plan had a focus area revised on 1/13/25 and 4/17/25 that indicated "I am on Psychoactive medications (medications that alter brain function, causing changes in perception, consciousness, mood, cognition, or behavior): antipsychotic and antidepressant to manage dx of Depression, bipolar disorder, insomnia, [and] schizophrenia." The 8/29/24 interventions included administering medications as ordered, monitoring his behavior	F0552	then monthly for 2 additional months, to ensure appropriate diagnosis or indication for use is included on physician orders, targeted symptoms are identified, non-pharmacological interventions are documented and attempted, required consent forms are completed thoroughly, and care plans are updated appropriately. DON or designee will present audit findings monthly in QAPI meeting for review and further recommendations to ensure ongoing compliance.	

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F0552 SS = D	Continued from page 86 while on medication, monitoring for any ill effects related to the medication, "Please monitor me for s/s [signs/symptoms] of adverse reactions to antidepressant and antipsychotic medications each shift." "Written consent for Psychotropic medication [was] obtained from the resident," in the care plan was dated 8/29/24. 4. Interview on 4/28/26 at 2:45 p.m. with director of nursing (DON) B and regional nurse consultant C revealed that they did not work at the facility in 2025, however they expected that the Medication Consent Form to have been completed and to include the doses of those medications, the frequency they were to be provided, the diagnosis, or the targeted behavior and that the risks and/or benefits of those medications were discussed with the resident or the resident representative. Written informed consents were not obtained from a resident or resident representative before beginning a psychotropic medication, and when the doses were adjusted. 5. Review of the provider's 4/28/25 Psychotropic Medication policy revealed "Informed Consent for psychotropic medications will be obtained from the resident or the resident representative at the initiation of the medication and for any medication dose increases. The Black Box Warning for antipsychotic medications will be included on the informed consent."	F0552		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure four of four sampled residents (2, 17, 28, and 48) had been assessed to determine their ability to safely self-administer medications, and a physician's order had been obtained to self-administer those medications. Findings include:	F0554	1. Residents #2, # 17, #28, and #48 were assessed regarding their ability to safely self-administer medications. Physician orders, medication administration practices, bedside medication storage, and care plans were reviewed and updated as indicated to ensure appropriate authorization, assessment, and documentation related to self-administration of medications.All residents were identified as having the potential to be affected by the deficient practice. A facility-wide audit was completed to identify residents independently administering medications or treatments and to ensure completed self-administration assessments, physician orders authorizing self-administration, and appropriate care plan documentation were in place. Any deficient findings identified during the audit process were corrected immediately. Licensed nurses were re-educated regarding the facility	6/2/2026

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F0554 SS = D	Continued from page 87 1. Observation on 4/21/26 at 8:30 a.m. of resident 2's room revealed she had a nebulizer (a device that converts liquid medication into an inhalable mist) and mask on her bedside table. The medication chamber had a clear liquid covering the bottom of the chamber. There was an open, empty unit dose container labeled formoterol (a medication used to relax the airways in the lungs to make breathing easier) lying on her bedside table beside the nebulizer. 2. Observation and interview on 4/21/26 at 10:52 a.m. with resident 2 in her room revealed the nurse would bring in her nebulizer medication, set up the nebulizer and leave the room. She stated the nurse would come back after she completed the nebulizer treatment. During the interview at 10:57 a.m. licensed practical nurse (LPN) V entered resident 2's room and handed resident 2 a nasal spray. Resident 2 administered the nasal spray to herself while LPN V put a liquid medication into her nebulizer medication chamber. She told resident 2 that she had set up her nebulizer treatment and after she was done with the interview resident 2 could turn on the nebulizer machine and start the nebulizer treatment then LPN V left the room. 3. Observation on 4/28/26 at 9:42 a.m. of resident 2's room revealed her nebulizer mask was lying on her nebulizer machine and the medication chamber had a hazy film on the inside of the chamber. 4. Review of resident 2's electronic medical record (EMR) revealed she was admitted to the facility on 2/16/26. Her Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her diagnoses included chronic obstructive pulmonary disease (COPD; a group of lung diseases that block airflow and can make it difficult to breathe). There was no medication self-administration assessments completed in resident 2's EMR to determine if she could safely self-administer medications. Her 4/23/26 care plan did not indicate she had been assessed to safely self-administer her medications. She had a 2/16/26 physician's order for budesonide suspension (a steroid used to treat lung inflammation) to be administered through her nebulizer two times a day for COPD. Formoterol (a medication to relax the airways to improve breathing)	F0554	policy and requirements for resident self-administration of medications. 2. Standardized the review process during admissions, quarterly assessments, and medication changes to determine whether residents request or qualify for self-administration privileges. DON or designee educated all licensed nurses regarding the self-administration of medications policy by 6/2/2026. Staff who are not in attendance will receive education on their next scheduled shift. 3. DON/designee will audit 5 samples weekly for 4 weeks, then monthly for 2 additional months, to ensure self-administration assessments are completed, physician orders are present, and care plans are updated appropriately for residents approved to self-administer medications. Audit findings will be reviewed monthly in QAPI meeting for further recommendations and ongoing compliance.	

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F0554 SS = D	Continued from page 88 to be administered through her nebulizer two times a day for COPD, ipratropium/albuterol (medication to relax the airways and decrease mucous) nebulizer to be administered every four hours as needed for difficulty breathing. None of these physician's orders that indicated resident 2 was able to self-administer the nebulizer medications. 5. Observation on 4/21/26 at 8:42 a.m. of resident 48's room revealed he had an assembled nebulizer mask lying on his bedside table. 6. Observation on 4/27/26 at 2:42 p.m. of resident 48 in his room revealed he was sitting in his recliner. He had his nebulizer mask on his face, and the nebulizer machine was running. There were no staff members in his room or in the hallway to monitor his administration of the nebulizer medication. 7. Observation on 4/28/26 at 2:02 p.m. revealed that LPN N stated to herself while walking down the hallway that she needed to go to resident 48's room and take his nebulizer mask off. LPN N walked down the hallway to his room; there were no other staff members in resident 48's room when she entered. 8. Review of resident 48's EMR revealed he was admitted to the facility on 4/26/22. His 3/13/26 BIMS assessment score was 15, which indicated his cognition was intact. His diagnoses included that he was legally blind, and he had COPD. He had a 2/29/25 physician's order for ipratropium/albuterol solution to be administered by nebulizer every six hours while he was awake. The physician's order did not include that resident 48 was able to self-administer his medications. He had a 4/26/22 medication self-administration assessment completed that indicated his visual impairment was a disqualifying factor, but the assessment indicated he could safely administer his medications after they were set up by a nurse. An 8/11/25 medication self-administration assessment indicated he did not want to self-administer his medications. His 4/23/26 care plan did not support he was assessed to safely self-administer his medications. 9. Interview and review of resident 2's EMR on 4/28/26 at 2:31 p.m. with LPN N revealed that	F0554		

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F0554 SS = D	Continued from page 89 resident 2 was the only resident who self-administered medications. LPN N would set up the nebulizer treatment for resident 2 to self-administer, and when it was completed resident 2 would remove the mask and turn off the nebulizer machine. Sometime between that nebulizer treatment and before the next scheduled nebulizer treatment LPN N would go back into resident 2's room and rinse out the nebulizer mask and let it air dry on a paper towel. LPN N stated there were certain diagnoses that would exclude a resident from being able to safely self-administer their medications. These diagnoses were indicated on the medication self-administration assessment that was to be completed by the nurse who admitted the resident to the facility. Review of resident 2's EMR revealed that a medication self-administration assessment was not completed upon her admission and there was no physician's order for her to self-administer her medications. LPN N stated that a self-administration assessment and a physician's order should have been completed before resident 2 was allowed to self-administer her medications. 10. Observation on 4/21/26 at 8:40 a.m. with resident 28 in her room revealed she was asleep, and there was a small plastic medication cup that contained a clear liquid on the bedside table. Resident 28 did not wake when she was spoken to. 11. Observation and interview on 4/21/26 at 9:34 a.m. with resident 17 in her room revealed that there was a small plastic medication cup that contained an off-white cream/gel-like substance on her bedside table. The cup had her initials on it. It appeared unused. She stated that staff members assisted her in putting cream on her shoulder and her bottom. She was unsure what the medication in the cup was or which area of her body it was to be used for. 12. Observation and interview on 4/21/26 at 12:19 p.m. with resident 28 in her room revealed that there was a small plastic medication cup that contained a clear liquid on the bedside table. She stated that at times it was hard for her to swallow and that she had an awful taste in her mouth. The medication in the plastic cup was for her "dry mouth." The nurse had left it there this morning before breakfast, and she had not used it. She liked to use it before and after her meals or when she had a bad taste in her	F0554		

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F0554 SS = D	Continued from page 90 mouth. She liked to use the mouthwash and suck on cough drops to make her mouth "taste" better. 13. Observation and interview on 4/22/26 at 2:04 p.m. with resident 28 in her room revealed there was a small plastic medication cup that contained a clear liquid on the bedside table. She stated that she ate her meals in her room, chose not to eat often, but thought that the medication in the cup helped make her mouth "a little better." 14. Observation and interview on 4/23/26 at 3:09 p.m. with resident 17 in her room revealed there was a small plastic medication cup that contained a small amount of an off-white cream in it on the table near her chair. The cup was not labeled. The cream appeared as if it had been used, as it was pressed against the side of the cup. Resident 17 was unsure what the cream was. She thought it might be the cream that the staff member put on her bottom. 15. Review of resident 28's electronic medical record (EMR) revealed she was admitted on 2/27/25, and her 1/16/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her diagnosis included bipolar disorder (a chronic mental health condition characterized by intense, alternating mood swings between highs and lows), dementia, anxiety, and depression. She had a 3/26/24 physician's order that indicated "May have cough drops at bedside." She had a 7/1/25 physician's order for "BIOTENE LIQ [liquid] DRY MTH [mouth] GIVE 15ML [milliliter] BY MOUTH THREE TIMES DAILY FOR DRY MOUTH Administered by clinician." There was no documentation of a physician's order for resident 28 to self-administer her mouthwash or her cough drops. Her April medication administration record (MAR) indicated her Biotene Mouthwash had been administered three times each day at 9:00 a.m., 1:00 p.m., and 8:00 p.m. Her 11/13/25 care plan indicated "Administer medications as ordered," "Administer dry mouth spray as ordered," and "I have reported at times that I have 'difficulty swallowing', this has been anxiety related in the past. I do refuse to take my medications at times d/t [due to] my 'mouth tastes bad'. Please encourage me to take a few deep	F0554		

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F0554 SS = D	Continued from page 91 breaths and try a sip of water to assess for any swallowing concerns. Administer anxiety medication as ordered." Her 2/27/24 Medication Self-Administration Evaluation indicated "Disqualifying Factors" included "noncompliance- Stated she does not want medication." Her 4/13/26 Medication Self-Administration Evaluation indicated that no medications listed as "Medications to be Self-Administered," and the remainder of the assessment was incomplete. 16. Review of resident 17's EMR revealed she was admitted on 12/16/21, and her 3/17/26 BIMS assessment score was 15, which indicated her cognition was intact. Her diagnosis included pain in the right hip, chronic pain syndrome, and Impingement syndrome (a common condition causing shoulder pain when the tendons of the rotator cuff or the bursa (fluid-filled sac) are compressed, rubbed, or pinched between the bones of the shoulder joint) of her right and left shoulders. She had physician's orders for "Menthol Gel 5 % [five percent]. Apply topically every 8 [eight] hours as needed for hips, buttocks, [and] back pain...," "Preparation H Cream 1 % [one percent] (Hydrocortisone) Apply to hemorrhoids topically as needed for hemorrhoids, apply as often as needed," "Apply lotion as needed," "Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)) Apply to neck, bilat [bilateral(both)] shoulders topically at bedtime for arthritic pain Apply 2 grams to neck and 2 grams to each shoulder topically at bedtime. Use [the included measurement] card to measure dose," and "Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)) Apply to R [right] knee topically every morning and at bedtime for Pain Apply 4 grams use [the included measurement] card to measure dose." There was no documentation of a physician's order for resident 17 to self-administer her creams. Her 9/30/25 care plan indicated to provide medications as ordered and to monitor for the "effectiveness" or "ill effects" of her medications. Her 3/11/26 Medication Self-Administration Evaluation indicated that no medications were listed as "Medications to be Self-Administered."	F0554		

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F0554 SS = D	Continued from page 92 17. Observation and interview on 4/27/26 at 3:40 p.m., with registered nurse (RN) D in resident 28's and resident 17's shared room revealed RN D identified that the clear liquid in the medication cup at resident 28's bedside was Biotene mouthwash. She stated that she had administered it to resident 28 before lunch, and resident 28 used the mouthwash, and then RN D discarded the remainder of the medication. Resident 28 became upset and wanted some of the mouthwash left at her bedside for her to use when she wanted it. RN D provided resident 17 with more mouthwash to keep her from escalating her behaviors. RN D confirmed that the medication cup with a cream in it at resident 17's bedside had been her topical menthol gel used for her hips and shoulder. She thought that resident 17 liked to put that on her shoulder herself when she had shoulder pain. RN D confirmed that resident 28 and resident 17 did not have a physician's order to self-administer medications. She expected that when a resident's physician ordered medications for self-administration, the medication self-administration evaluation would have been completed. 18. Interview on 4/28/26 at 2:50 p.m. with director of nursing (DON) B and regional nurse consultant (RNC) C regarding residents self-administering medications revealed there were no residents in the facility at that time who had been assessed or had a physician's orders to self-administer medications. DON B was aware that resident 28 had Biotene mouthwash at her bedside and attempted to take it away from her yesterday (4/27/26). Resident 28 became upset and wanted the mouthwash left at her bedside. She was unaware that resident 28 had a physician's order for cough drops at bedside. DON B felt that a self-administration evaluation and the need for a physician's order would depend on what the medications were. She faxed resident 28's physician yesterday (4/27/26) to request an over the counter Biotene lozenge that could be left at resident 28's bedside. DON B was unsure if resident 28 would require a medication self-administration evaluation for that medication. DON B expected that the medication self-administration evaluation would be completed on admission to the facility. If a resident was unable to self-administer medications at the time of the	F0554		

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F0554 SS = D	Continued from page 93 evaluation but the physician added a medication at a later time, then the resident would be allowed to self-administer that medication because the physician had ordered it. DON B and RNC C thought that the cream in the medication cup left at resident 17's bedside had been a barrier cream that the certified nurses assistants used when they completed a resident's personal care that did not require a physician's order or a medication self-administration evaluation, but confirmed that they had not seen the cream to identify it. RNC C expected that no physician-ordered pills, liquids, or creams would be left at the resident's bedside if the resident did not have an order to self-administer that medication and a medication self-administration evaluation had been completed that determined the resident was safe to self-administer that medication. She expected the medication self-administration evaluations to be completed on admission, quarterly, and if there was a new medication that the resident wanted to self-administer. 19. Review of the provider's January 2018 Self-Administration of Medications policy revealed "If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process." "For those residents who self-administer, the interdisciplinary team verifies the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis or when there is a significant change in condition." "The results of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record, on the care plan. For each medication authorized for self-administration, the label contains a notation that it may be self-administered." "If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside storage is conducted." "Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer."	F0554		

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F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F0605	1. Resident #33's psychotropic medication regimen was reviewed by the physician, pharmacist consultant, nursing leadership, and interdisciplinary team. Resident #33's medical record, physician orders, diagnoses, behavioral documentation, consent forms, and care plan were reviewed and updated as indicated to reflect the clinical indication for psychotropic medication use, target symptoms, documented behaviors, and non-pharmacological interventions attempted or to be attempted. All residents were identified as having the potential to be affected by the deficient practice. A facility-wide audit was completed for residents receiving psychotropic medications to ensure physician orders included an appropriate diagnosis or clinical indication, behavioral symptoms and target behaviors were identified, non-pharmacological interventions were documented and attempted, required consent forms were complete, and care plans reflected psychotropic medication use and interventions appropriately. Any deficient findings identified during the audit process were corrected immediately. Licensed nurses and interdisciplinary team members were re-educated regarding psychotropic medication requirements, resident rights, non-pharmacological interventions, and prohibition of psychotropic medications for staff convenience or discipline. 2. The facility implemented a revised psychotropic medication review system to ensure interdisciplinary review of diagnoses, behaviors, target symptoms, non-pharmacological interventions, consent forms, and care plan documentation prior to implementation or continuation of psychotropic medication therapy. DON or designee educated the interdisciplinary team regarding the psychotropic medication policy and documentation requirements by 6/2/2026. Staff not in attendance will receive education on their next scheduled shift. New psychotropic medication orders will be reviewed by nursing leadership or designee prior to implementation to ensure required documentation is complete.	6/2/2026

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F0605 SS = D	Continued from page 95 (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or	F0605	3. DON/designee will audit 5 residents receiving psychotropic medications weekly for 4 weeks, then monthly for 2 additional months, to ensure appropriate diagnosis or indication for use, targeted symptoms, non-pharmacological interventions, consent forms, and care plan updates are completed appropriately. Audit findings will be reviewed monthly in QAPI meeting for further recommendations and ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435068	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA WATERTOWN	415 FOURTH AVE NE , WATERTOWN, South Dakota, 57201

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F0605 SS = D	Continued from page 96 she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure there was documented need, treatment alternatives, non-pharmacological interventions, and a specific condition identified for one of one sampled resident (33) who was started on an antipsychotic (a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions) medication. Findings Include: 1. Interview on 4/21/26 at 8:56 a.m. with resident 33 in her room revealed she stated in the middle of a conversation about her having a doctor appointment, "The old cook in the dining room told another person to give me that piece [of food] because I do not pay my taxes, That made me mad because I paid taxes most of my life," and then went on to discuss the nursing staff in the facility. 2. Review of resident 33's EMR revealed she was admitted to the facility on 12/4/25. Her 3/26/26 Brief Interview of Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact. Her diagnoses included depression. There was a 12/4/25 physician's order for sertraline (an antidepressant medication) 100 milligrams (mg) every day at bedtime for depression. She had a 3/6/26 physician's order quetiapine (an antipsychotic medication) 25 mg at bedtime that did not indicate a diagnosis that the medication was being prescribed to treat. Her Antipsychotic Medication Consent Form listed "Quetiapine" and was signed and dated by the resident representative and director of nursing (DON) B on 3/20/26. The form indicated the antipsychotic medication was being used for resident 33's "mood". The area on the form where the alternatives to the prescribed medications that "may be used instead of this	F0605		

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F0605 SS = D	Continued from page 97 medication" was blank. The area on the Antipsychotic Medication Consent form labeled, "Check Here if Taking" before each listed antipsychotic medication's warnings did not have a check mark in front of the warnings for quetiapine. She had a 3/29/26 physician's order to stop the quetiapine and start olanzapine (an antipsychotic medication) 5 mg daily at bedtime. There was no diagnosis identified on the physician's order that indicated what olanzapine was prescribed for. Her Antipsychotic Medication Consent Form listed "Olanzapine" and was signed and dated by the resident representative and DON B on 3/30/26. The area on the form that indicated what the olanzapine was ordered for was blank. The area on the form where the alternatives to the prescribed medications that "may be used instead of this medication" was blank. The area on the Antipsychotic Medication Consent form labeled, "Check Here if Taking" before each listed antipsychotic medication's warnings did not have a check mark in front of the warnings for olanzapine. Review of resident 33's progress notes from 1/1/26 to 4/20/26 revealed the first progress note related to behaviors was on 3/25/26 and stated, "Becomes very agitated and combative with attempts to assist resident. Grabs [the] staff, kicks, hits, scratches, and pinches. 'You just get out of here! I don't trust any of you!' Mimics sarcastically what [the] staff are asking/saying to her." A 3/28/26 progress note stated, "Resident taking papers off nurse [nurses'] desk and ripping them apart. Yelling and name calling to [the] nurse and other staff." A 3/29/26 progress note stated "Resident is name calling to [the] staff, arguing with [the] staff. Reaching out to pinch another resident." A 4/13/26 progress note stated, "yelling at [the] staff to 'go to hell,' 'don't look at me.' 'you're all evil.' Unable to redirect [the resident]. Resident spit at [the] writer." Review of resident 33's 4/22/26 care plan revealed that her care plan did not support she was on an antipsychotic medication, that she had behaviors, or any nonpharmacological interventions that may be used when she had behaviors. The use of a psychotropic (drugs that affect brain activities associated with mental processes and behavior) medication was only identified in resident 33's care plan within the focus area related to her fall risk. It did not indicate target symptoms for the use of her sertraline or non-pharmacological interventions. 3. Interview on 4/28/26 at 2:09 p.m. with Minimum	F0605		

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F0605 SS = D	Continued from page 98 Data Set (MDS)/registered nurse (RN) H revealed she was responsible for updating the nursing portion of resident care plans. If a resident was taking an antipsychotic medication, she would expect that to be on their care plan as well as interventions to help alleviate their behaviors. 4. Interview and review of resident 33's EMR on 4/28/26 at 2:46 p.m. with licensed practical nurse (LPN) N revealed that resident care plans should be updated to accurately reflect the current needs of each resident. Resident 33 had intermittent behaviors such as being rude, abrupt, and blunt to staff and other residents. She thought the CNAs experienced her behaviors during cares more than the nurses witnessed them. She acknowledged that resident 33's behaviors as well as non-pharmacological intervention should be identified in her care plan. LPN N stated she did not know if resident 33's behaviors were actual behaviors or if they were her personality because her family was aware of the behaviors since she was admitted and did not seem troubled by them. LPN N verified there was no diagnosis for the administration of resident 33's olanzapine. She stated each medication should have a diagnosis to indicate what it was being administered for, and an antipsychotic medication cannot be given just because a resident has behaviors. 5. Interview on 4/29/26 at 10:09 a.m. with DON B revealed that she expected all antipsychotic medications to have a diagnosis to indicate what the antipsychotic medication was being used for. If a medication started after the resident was in the facility, she expected the nurse who received the order to confirm there was a diagnosis for that medication and if there was not, she expected that nurse to call or fax the physician to get the diagnosis for that medication. 6. Review of the provider's 4/28/25 Psychotropic Medications policy revealed, "Psychotropic medications will be used only when it is necessary to treat a specific condition after non-pharmacological interventions have been attempted to assist with residents displaying mood, behavior, or sleep concerns." "Resident's receiving psychotropic medication will have adverse side effects and target behaviors addressed in the care plan and will be monitored, recorded, and	F0605		

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F0605 SS = D	Continued from page 99 summarized each quarter." Assessments will include "resident specific behaviors, non-pharmacological interventions attempted and the resident's response to the intervention."	F0605		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with	F0628	1. Resident #54's discharge/transfer notification to the Office of the State Long-Term Care Ombudsman was completed on 4/27/2026 after the facility identified the missing notification. The residents' discharge record was reviewed to ensure discharge documentation was complete and required parties were notified as indicated. All residents were identified as having the potential to be affected by the deficient practice. A facility-wide review was completed for residents discharged or transferred within the previous 90 days to determine whether required Ombudsman notifications and discharge documentation were completed appropriately. Any deficient findings identified during the audit process were corrected immediately. 2. The facility revised and reinforced the discharge and transfer process through implementation of a standardized discharge/transfer checklist, assignment of responsibility for Ombudsman notification, and required review of discharge documentation prior to record closure. On 5/13/2026, the IDT were re-educated by the RNC regarding discharge requirements, required notifications, and documentation expectations. Leadership oversight was strengthened to verify required notifications, supporting documentation, and record review are completed timely and accurately before discharge records are finalized. Ongoing monitoring of discharge records will be completed through routine management review and QAPI oversight to ensure continued compliance. 3. Administrator/designee, or designee will audit all discharges and transfers weekly for 4 weeks, then 5 randomly selected discharges monthly for 2 additional months, to ensure Ombudsman	6/2/2026

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F0628 SS = D	Continued from page 100 paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F0628	notifications, transfer/discharge notices, bed-hold notices, discharge summaries, and required documentation are completed appropriately. Audit findings will be reviewed monthly in QAPI meeting for further recommendations and ongoing compliance.	

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F0628 SS = D	Continued from page 101 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F0628		

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F0628 SS = D	Continued from page 102 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review the provider failed to ensure the Office of State Long-Term Ombudsman (an advocate of residents' overall quality of care and rights) was notified when a resident discharged from the facility, for one of three sampled residents (54). Findings include: 1. Review of resident 54's electronic medical record (EMR) revealed he had been discharged on 1/27/26 to another facility. His primary care physician (PCP)	F0628		

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F0628 SS = D	Continued from page 103 was notified of intent to discharge on 1/26/26 and the provider received orders on 1/26/26 to discharge. His representative signed the discharge summary on 1/27/26. There was no documentation that the Office of State Long-Term Care Ombudsman was notified of resident 54's transfer to another facility. 2. Interview on 4/27/26 at 10:57 a.m. with Social Services Designee (SSD) J revealed that she did not complete the notifications to the Office of State Long-Term Ombudsman. She thought administrator A completed those notifications. 3. Interview on 4/27/26 at 11:00 a.m. with administrator A revealed she was not responsible for notifying the Office of State Long-Term Ombudsman of resident discharges. When asked who oversaw those notifications, she stated, "I will have to ask the team and get back to you." The form "Report Discharge or Transfer to Department of Human Services (DHS) Ombudsman Program" was completed on 4/27/26 at 11:12 a.m. that had been submitted by SSD J. It listed the discharge date for resident 54 as 1/26/26. 4. Review of the provider's revised April 28, 2025 Discharge and Transfer of Residents/Bed Hold Policy revealed "To ensure a safe transition is planned for any resident with a discharge or transfer to another setting. To ensure adequate care is given to any resident with a change of condition. The Notice of Transfer/Discharge form and bed hold policy will be given to the resident or resident representative prior to the discharge or transfer. If resident is being transferred emergently, the form will be given as soon after the transfer as practicable. For South Dakota, ombudsman are notified by the following: Report the discharge/transfer and upload the Notice of Discharge form on the following link: http://sddhs.seamlessdocs.com/f/report discharge transfer ombudsman program."	F0628		
F0641 SS = D	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	F0641	1. Resident #2 and Resident #40's Minimum Data Set (MDS) assessments were reviewed and corrected to accurately reflect PASRR Level II status and qualifying diagnoses. Corrections were submitted in accordance with MDS correction procedures. The interdisciplinary team reviewed the residents' diagnoses, PASRR documentation, and related MDS coding requirements to ensure the medical records accurately reflected the residents' status. All residents were identified as having the potential to be affected by the	6/2/2026

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F0641 SS = D	Continued from page 104 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. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, policy review, and 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 review, the provider failed to ensure two of two sampled residents' (2 and 40) Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop and individualized care plan to manage the resident's care needs) assessments were accurately coded for the areas required for the Pre-Admission Screening and Resident Review (PASRR) (a mandatory federal process that ensures people with mental illness or intellectual disabilities are not inappropriately placed in nursing homes). Findings Include: 1. Review of resident 2's EMR revealed she was admitted to the facility on 3/4/26 from another long-term care facility. Her diagnoses included bipolar disorder (mental condition causing extreme	F0641	deficient practice. A facility-wide audit was completed to review PASRR Level II determinations, diagnoses related to serious mental illness, intellectual disability, or related conditions, and recent admission and comprehensive MDS assessments. Any deficient findings identified during the audit process were corrected immediately. The MDS Coordinator, Social Services, and interdisciplinary team members were re-educated regarding PASRR requirements and accurate MDS coding practices. 2. The facility reinforced processes to ensure PASRR Level II determinations and qualifying diagnoses are accurately reviewed and coded on comprehensive MDS assessments. The MDS Coordinator and Social Services will complete a joint review of PASRR documentation, qualifying diagnoses, and supporting records during the admission process and prior to final MDS submission. Staff were re-educated regarding PASRR requirements and MDS coding expectations. Ongoing management oversight will include routine audits of comprehensive assessments to verify PASRR status and qualifying diagnoses are accurately documented and coded, with findings reviewed through the QAPI process to ensure continued compliance. 3. Administrator/designee will audit 5 resident samples weekly for 4 weeks, then monthly for 2 additional months, to ensure PASRR documentation, Section A1500 coding, and qualifying diagnoses are coded accurately. Audit findings will be reviewed monthly in QAPI meeting for further recommendations and ongoing compliance.	

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F0641 SS = D	Continued from page 105 shifts in mood, energy, and activity levels), generalized anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), adjustment disorder (a short-term, stress-related mental health condition triggered by an identifiable life change or event), and binge eating disorder (regularly eating a lot of food over a short period of time until you are uncomfortable). Her 1/24/23 level II [2] PASRR stated, "This individual was not exempt from a Level II review and the following determination was made: Requires level of services provided by Medicaid certified swing bed to nursing facility due to the individual's physical or mental conditions." "Based on the documentation provided for the Level II PASRR Review, this individual meets the minimum standards for Nursing Facility admission at this time." Item A1500 of her 3/4/26 comprehensive MDS assessment was coded "No" to the question "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?" 2. Review of resident 40's electronic medical record (EMR) revealed on 6/17/24 the resident had a diagnosis of major depressive disorder (serious, common, and treatable mental health condition characterized by persistent, intense sadness or a loss of interest in activities). Further review of the resident 40's MDS within the EMR revealed A1500 was marked "no", indicating the resident does not have a serious mental illness and/or intellectual disability or a related condition. 3. Interview and review of resident 2's and resident 40's EMR on 4/28/26 at 3:27 p.m. with MDS/registered nurse (RN) H and social service designee (SSD) J revealed the residents' PASRRs were usually completed by the hospital staff before they admitted to the facility. Upon admission MDS/RN H and SSD J reviewed the resident's diagnoses and medications and compared them with the appropriate boxes on the completed PASRR screening to be sure the PASRR had been completed accurately prior to the resident's admission to the facility. If there was something omitted or not completed accurately SSD would resubmit the PASRR screen. MDS/RN H was responsible for entering the PASRR information into the residents' MDS assessments. MDS/RN H acknowledged she had coded resident 2's 3/4/26 section A1500 inaccurately.	F0641		

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F0641 SS = D	Continued from page 106 4. Review of resident 40's electronic medical record (EMR) revealed on 6/17/24 the resident had a diagnosis of major depressive disorder (serious, common, and treatable mental health condition characterized by persistent, intense sadness or a loss of interest in activities). Further review of the resident 40's MDS within the EMR revealed A1500 was marked "no", indicating the resident does not have a serious mental illness and/or intellectual disability or a related condition. 5. Interview on 4/28/26 at 3:30 p.m. with MDS/registered nurse (RN) H confirmed resident 40 had a qualifying major depressive disorder upon admission, indicating the facility should have marked "yes" for questions A1500 on the MDS, and that section was marked "no" on 4/15/2026. 6. Review of provider's 5/14/25 Preadmission Screening and Resident Review PASRR policy revealed "The Preadmission Screening and Resident Review (PASRR) is a federal requirement to ensure 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; Provided with the MI/ID/DD services they need, including specialized services." "Individuals who have or are suspected to have MD [mental disorder], ID [intellectual disability] or a related condition (as indicated by a positive level I screen) may not be admitted to a Medicaid-certified nursing facility unless approved based on Level II PASARR [PASRR] evaluation and determination." 7. Review of the CMS Long-Term Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 revealed that Section N, Page N6 and N7," Steps for Assessment: 1. Review the resident's medical record for documentation that any of these medications were received by the residents and for the indication of their use during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). 2. Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home (e.g., valium given in the emergency room)." 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	F0641		

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F0641 SS = D	Continued from page 107 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".	F0641		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to complete a Level II (2) Preadmission Screening and Resident Review (PASRR) (a mandatory federal process that ensures people with mental illness or intellectual disabilities are not inappropriately placed in nursing homes) for one of one sampled resident (40) with a qualifying mental health diagnosis and resubmit a Level I screening PASRR for one of one sampled resident (33) who was newly prescribed an antipsychotic (a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions) medication. Findings include: 1. Review of resident 40's electronic medical record (EMR) revealed she was admitted to the facility on 4/3/26 and had a diagnosis of major depressive disorder (a serious, common, and treatable mental health condition characterized by persistent, intense sadness or a loss of interest in activities) that was documented on 6/17/24.	F0644	1. Resident #40's PASRR documentation, diagnoses, and admission records were reviewed. A PASRR Level I screening was completed and submitted for review to determine if Level II evaluation requirements were indicated. Resident #33's medical record, psychotropic medication orders, and PASRR documentation were reviewed, and a new PASRR Level I screening was submitted following identification of antipsychotic medication use and change in mental health status. Care plans, assessments, and supporting documentation were updated as appropriate to reflect PASRR-related findings and recommendations. All residents were identified as having the potential to be affected by the deficient practice. A facility-wide audit was completed for residents with serious mental illness diagnoses, prescribed antipsychotic medications, PASRR Level I or II screenings, and newly admitted residents within the previous 90 days. Any deficient findings identified during the audit process were corrected immediately. 2. The facility implemented a standardized PASRR review process for all admissions, significant change assessments, new psychiatric diagnoses, and initiation of antipsychotic medications. Daily clinical meetings will include review of psychiatric diagnoses, psychotropic medication changes, and potential PASRR triggers to ensure timely identification, referral, and follow-up. Interdisciplinary staff were re-educated regarding PASRR requirements and responsibilities. Ongoing management oversight will include routine audits of PASRR screenings, referrals, and documentation, with findings reviewed through the QAPI process to ensure continued compliance. 3. Administrator/designee will audit 5 resident samples weekly for 4 weeks, then monthly for 2 additional months, to review new admissions, psychotropic medication changes,	6/2/2026

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F0644 SS = D	Continued from page 108 2. Resident 40's 3/31/26 PASRR level 1 screening form did not indicate a confirmed or suspected mental illness diagnosis. 3. Review of resident 40's PASRR documentation revealed no additional PASRR level 1 screening was completed, nor was a PASRR level 2 submitted to the appropriate state agencies for review. 4. Interview on 4/28/26 at 3:28 p.m. with social services designee (SSD) J revealed that she did not complete a PASRR level 2 on resident 40. She was not aware of the Major Depressive Disorder diagnosis for the resident during her admission process. 5. Review of resident 33's EMR revealed she was admitted to the facility on 12/4/25. Her 3/26/26 Brief interview of Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact. Her diagnoses included depression. She had a level I PASRR screening before her admission to the facility. She had a 3/6/26 physician's order quetiapine (an antipsychotic medication) 25 milligrams (mg) at bedtime. There was no supported documentation of a diagnosis for the prescribed medication. She had a 3/29/26 physician's order to stop the quetiapine and start olanzapine (an antipsychotic medication) 5 mg daily at bedtime. There was no diagnosis identified on the physician's order that indicated what olanzapine was prescribed for. There was no documentation that resident 33's PASRR level I screening had been resubmitted for evaluation after she was prescribed antipsychotic medications. 6. Interview and review of resident 33's EMR on 4/28/26 at 3:27 p.m. with MDS/registered nurse (RN) H and social service designee (SSD) J revealed the residents' PASRRs were usually completed by the hospital staff before they were admitted to the facility. Upon admission, MDS/RN H and SSD J reviewed the residents' diagnoses and medications and compared them with the appropriate boxes on the completed PASRR screening to be sure the PASRR had been completed accurately before the resident's admission to the facility. If there was something omitted or not completed accurately, SSD J would resubmit the PASRR screen to the state designated authority. If a resident was started on a new psychotropic or antipsychotic medication, or they were diagnosed with a serious mental illness, intellectual disability (a condition characterized by	F0644	PASRR Level I and II documentation, and significant change assessments requiring PASRR review. Audit findings will be reviewed monthly in QAPI meeting for further recommendations and ongoing compliance.	

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F0644 SS = D	Continued from page 109 significant limitations in both intellectual functioning (learning, reasoning, problem-solving) and adaptive behavior (everyday social and practical skills), or developmental disability (a chronic mental or physical impairment that emerges before age 22, lasts throughout a person's lifetime, and causes substantial functional limitations in major life activities), a new PASRR level I screening would be submitted to determine if the resident needed a level II PASRR. When a resident was started on a new medication or diagnosed with a serious mental illness, intellectual disability, or developmental disability, MDS/RN H and SSD J were to be notified of this change in their daily morning meetings. SSD J stated she was not aware that resident 33 had an antipsychotic medication added to her medication list. MDS/RN H acknowledged that the addition of an antipsychotic medication to resident 33's regimen should have triggered them to complete a new PASRR screening. 7. Review of provider's 5/14/25 Preadmission Screening and Resident Review PASRR policy revealed "The Preadmission Screening and Resident Review (PASRR) is a federal requirement to ensure 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; Provided with the MI/ID/DD services they need, including specialized services." "A negative Level I screen permits admission to proceed and ends the pre-screening process unless possible serious mental disorder with intellectual disability arises later."	F0644		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the staff followed nursing professional standards of practice	F0658	1. Resident #40's elevated blood glucose levels were reported to the physician on 4/30/2026. Resident #40's blood glucose monitoring orders, physician notification parameters, and related documentation were reviewed and updated as indicated. All residents were identified as having the potential to be affected by the deficient practice. A facility-wide audit was completed for residents receiving blood glucose monitoring to verify physician notification parameters were present and abnormal blood glucose readings were addressed appropriately. Any deficient findings identified during the audit process were corrected immediately.	6/2/2026

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F0658 SS = D	Continued from page 110 for notifying the physician of elevated blood glucose (the amount of glucose—a type of simple sugar—present in your blood at any given time) for one of one sampled resident (40). Findings include: 1. Review of resident 40's electronic medical record (EMR) revealed from 4/8/26 to 4/12/26 there were seven occurrences where resident 40's blood glucose results were over 400 milligrams per deciliter (mg/dL), indicating the concentration of glucose in the blood. Review of resident 40's EMR revealed six of the seven elevated blood glucose results were not reported to the physician. Review of her blood glucose orders revealed that blood glucose checks were started on 4/3/26 two times per day with no parameters for when to notify the physician. Review of resident 40's insulin orders revealed that there were no parameters for the blood glucose testing included with the 4/13/26 sliding scale insulin orders. 2. Interview on 4/28/26 at 10:07 a.m. with licensed practical nurse (LPN) KK revealed that she would contact the doctor for blood glucose levels as per the parameters on the orders. If there were no parameters within the orders, and a blood glucose level was elevated or low she would contact the director of nursing (DON) and then the doctor's office for further orders or instruction. 3. Interview on 4/28/26 at 11:19 a.m. with DON B revealed that if the ordering doctor does not give parameters for a resident's blood glucose, then she would expect the nursing staff to use the protocol/standing orders. 4. Interview on 4/29/26 at 11:47 a.m. with the medical director (MD) LL revealed that it is her expectation that the physicians ordering the blood glucose and sliding scale insulin would have given orders with parameters of when the staff should contact the doctor. She further stated that she would expect the staff to contact the doctor and ask for parameters for the blood glucose checks if it was not indicated in the order. MD LL stated she would consider the protocol	F0658	2.The facility reinforced processes to ensure abnormal blood glucose results are reviewed timely, reported to the physician according to established parameters with use of facility protocol orders when provider-specific parameters are absent and required clarification follow-up when orders are incomplete. Licensed nurses were re-educated regarding physician notification requirements, abnormal blood glucose reporting, documentation expectations, and follow-up responsibilities. Nursing management will review physician orders to verify notification parameters are present and obtain clarification when needed. Ongoing management oversight will include routine audits of blood glucose monitoring records, physician notifications, and follow-up documentation. 3. DON/designee will audit 5 residents weekly for 4 weeks, then monthly for 2 additional months, to review blood glucose results, abnormal values, physician notification when outside parameters, and follow-up interventions and documentation. Audit findings will be reviewed monthly in QAPI meeting for further recommendations and ongoing compliance.	

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F0658 SS = D	Continued from page 111 standing orders to be an acceptable guideline for nursing to follow if they did not have parameters and she would expect that staff would contact a doctor if a blood glucose was over 400 mg/dL. 5. Review of the provider's Protocol Orders revealed the staff should contact the medical doctor (MD) if the blood glucose is less than 60 [mg/dl] or greater than 400 [mg/dl] unless otherwise specified.	F0658		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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 ensure accurate and complete documentation for the	F0755	1. Resident #9's fentanyl patch documentation was reviewed. The transdermal patch controlled drug record could not be corrected due to inability to verify missing documentation after the fact. Related medication administration, patch removal, and destruction documentation processes were reviewed with nursing staff. All residents were identified as having the potential to be affected by the deficient practice. A facility-wide audit was completed for residents receiving controlled substance transdermal patches, hospice-controlled medications, and other controlled substances requiring destruction documentation to verify documentation of patch application, removal, destruction, and presence of required witness signatures. Any deficient findings identified during the audit process were corrected immediately. 2. The facility reinforced processes to ensure controlled substance transdermal patch administration, removal, destruction, and related documentation are completed accurately and timely. DON or designee educated licensed nurses regarding controlled substance handling requirements, accurate completion of transdermal patch-controlled drug records, documentation requirements for administration, removal, destruction, missing medications, and two-nurse witness requirements by 6/2/2026. Staff not in attendance will receive education on their next scheduled shift. 3. DON or designee will audit 5 resident samples weekly for 4 weeks, then monthly for 2 additional months, to review transdermal patch documentation, destruction records, and witnessed destruction documentation signed by two nurses. Audit findings will be reviewed	6/2/2026

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F0755 SS = D	Continued from page 112 destruction of fentanyl patches (potent long-acting pain patch applied on the skin) for one of one sampled resident (9). Findings include: 1. Review of the providers 4/2/26 SD DOH FRI revealed on 3/30/26 a fentanyl patch was ordered by hospice and resident 9 refused to have the fentanyl patch applied. On 3/31/26 licensed practical nurse (LPN) V placed the fentanyl patch on resident 9. On 4/2/26 LPN N went into resident 9's room to check the placement of her fentanyl patch and found the patch to be missing. Resident 9's family member stated he was present on 3/31/26 when LPN V placed the fentanyl patch on resident 9. The fentanyl patch was searched for by nursing and laundry staff but was not found. Resident 9 was interviewed about the missing fentanyl patch. She did not recall scratching the patch off. After that patch was not found, the plan was made to place the fentanyl patch on resident 9's back to prevent her from scratching the patch off. The medication administration record (MAR) was revised to include scheduled fentanyl patch placement checks every shift. Resident 9's care plan was updated to reflect the placement of the fentanyl patches on her back. 2. Review of the provider's 4/12/26 SD DOH FRI revealed that on 4/12/26 director of nursing (DON) B was notified by registered nurse (RN) T that she discovered resident 9's fentanyl patch to be missing when she was checking the patch's placement. On 4/10/26 the dose for resident 9's fentanyl patch had increased. LPN V entered the new order and did not include the additional instructions to place the fentanyl patch on resident 9's back. On 4/11/26 RN T placed the fentanyl patch on resident 9's right chest. On 4/12/26 at 1:20 p.m. RN AA documented the fentanyl patch was on resident 9's mid right upper back. On 4/12/26 at 7:00 p.m. RN T was unable to find the fentanyl patch. That patch was not found. After that patch was not found the placement monitoring was increased to every four hours. Other forms of pain management were discussed with hospice at that time. 3. Interview on 4/21/26 at 10:18 a.m. with resident 9's family member revealed he was in the room when the nurse put the fentanyl patch on resident 9 on 3/31/26. He had been notified two times that	F0755	monthly in QAPI meeting for further recommendations and ongoing compliance.	

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F0755 SS = D	Continued from page 113 resident 9's fentanyl patch was missing. He stated that both times the fentanyl patch went missing the patch was placed on her chest. Resident 9 scratched frequently due to her liver disease, and he thought she probably scratched the fentanyl patches off. He stated she continued to use fentanyl patches for pain control and there had been no further lost patches. 4. Review of resident 9's EMR revealed she was admitted on 2/25/26 receiving hospice services. There was a 3/30/26 physician's order to start Fentanyl patch 12 microgram (mcg) per hour, change the patch every 72 hours. On 3/31/26 at 8:30 a.m. the fentanyl patch 12 mcg per hour was placed on resident 9. On 4/2/26 the fentanyl patch was missing. The patch was replaced on 4/2/26 at 12:45 p.m. On 4/3/26 the fentanyl patch dose was increased to 25 mcg per hour, with orders to change the patch every 72 hours. On 4/3/26 at 10:30 a.m. a 12 mcg fentanyl patch was placed on resident 9 and a second fentanyl patch was placed on her at 4:30 p.m. due to the physician's ordered fentanyl patch dose increase. On 4/10/26 the fentanyl patch increased to 37 mcg per hour, change the patch every 72 hours. On 4/11/26 at 7:00 p.m. a 12 mcg per hour patch and a 25 mcg per hour patch were applied to resident 9. On 4/12/26 at 7:00 p.m. resident 9's fentanyl patches were missing. On 4/13/26 at 10:00 a.m. a 12 mcg and 25 mcg per hour fentanyl patch were put on resident 9. On 4/13/26 there was a physician's order to place the fentanyl patches on resident 9's back only. On 4/22/26 there was a physician's order to increase resident 9's fentanyl patch dose to 50 mcg per hour, change every 72 hours. 5. Review of resident 9's April 2025 Transdermal Patch Controlled Drug Record revealed the fentanyl patch that was removed on 4/3/26 did not have a date or time when it was destroyed. The two 12 mcg fentanyl patches that were applied on 4/3/26 were not documented as being destroyed. On 4/6/26 at 4:30 p.m. the number five 25 mcg fentanyl patch was signed out to be administered to resident 9. On 4/6/26 at 4:30 p.m. 25 mcg fentanyl patch five was documented as having been destroyed. On 4/9/26 at 4:30 p.m. the number four 25 mcg patch was administered at 4:30 p.m. and the number four 25mcg patch was documented as destroyed on 4/9/26 at 4:30 p.m.	F0755		

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F0755 SS = D	Continued from page 114 On 4/11/26 at 7:00 p.m. the number three 25 mcg fentanyl patch and the number one 12 mcg fentanyl patch were signed out to be administered and on 4/12/26 at 5:15 a.m. the number three 25 mcg fentanyl patch and the number one 12 mcg fentanyl patch were documented as having been destroyed. The 4/12/26 missing patch was not documented on the Transdermal Patch Controlled Drug Record as missing. On 4/13/26 at 10:00 a.m. the number two 25 mcg patch was signed out to be administered On 4/22/26 at 9:00 p.m. the number five fentanyl 50 mcg per hour patch was signed out to be administered and on 4/22/26 at 9:15 p.m. the number five 50 mcg fentanyl patch was documented as destroyed. On 4/25/26 at 9:00 p.m. the number four fentanyl 50 mcg patch was signed out to be administered and on 4/26/26 at 12:30 a.m. the number four 50 mcg fentanyl patch was documented as destroyed. The third 50 mcg fentanyl patch was documented as destroyed without a date or time. 6. Interview and review of resident 9's Transdermal Patch Controlled Drug Record on 4/29/26 at 9:12 a.m. with LPN V revealed she thought the Transdermal Patch Controlled Drug Record was difficult to understand. Resident 9's fentanyl patches were applied by the night nurses, unless a patch was found to be missing during a different shift. If there was not a second nurse available when the fentanyl patch was removed the nurse who removed the fentanyl patch would put the used patch in a medication cup and store it in the locked controlled medication drawer until the day shift nurse arrived and could witness the destruction. Two nurses were expected to witness the destruction of the fentanyl patch in the drug destruction bottle that was kept in the medication room. The date and time the fentanyl patch was destroyed would then be documented on the Transdermal Patch Controlled Drug Record. LPN V did not know how a fentanyl 50 mcg patch was documented as destroyed on the same day the first fentanyl 50 mcg patch was placed on resident 9. 7. Interview and review of resident 9's Transdermal Patch Controlled Drug Record on 4/29/26 at 10:09 a.m. with the director of nursing (DON) B revealed that resident 9 received her fentanyl patches from hospice. When controlled medications were provided by hospice, they were not accompanied by a controlled medication tracking form. Hospice gave them the Transdermal Patch Controlled Drug Record	F0755		

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F0755 SS = D	Continued from page 115 to track the removal of the fentanyl patch from the medication cart for application and the destruction of the fentanyl patch once it was removed from the resident. She expected the Transdermal Patch Controlled Drug Record to be completed accurately to include the date and time the patch was removed from the medication cart, and when it was destroyed. The fentanyl patches were to be destroyed by two licensed nurses as soon as they were removed. If the patch was removed after 11:00 p.m. there was only one nurse in the facility, so she expected that fentanyl patch to be stored in a plastic medication cup with the resident's initials on the cup. That cup was to be placed in the locked controlled medication drawer in the medication cart until the morning nurses arrived at the facility to witness the destruction of that fentanyl patch. DON B stated resident 9's fentanyl patch administration times changed when there was a change in the physician's order or when the patches were missing so a new patch could be placed immediately. There were two times resident 9's patches were reported to be missing on 4/2/26. The first time the patch was placed on her chest. Resident 9 scratched frequently due to her lever failure. DON B had looked for the patch and it was unable to be found. At that time, it was discovered that the order to check the fentanyl patches placement every shift had not been entered into the computer when the order for the fentanyl patch was entered, so the fentanyl patch placement had not been checked every shift. After that patch was unable to be found, an order to check for the fentanyl patches placement every shift was put into the computer. When the second fentanyl patch was missing on 4/13/26 the fentanyl patch placement checks were scheduled every four hours. She expected that the location of the patch be documented in the MAR when the patches were placed, and when the placement was checked. DON B acknowledged that the documentation on the Transdermal Patch Controlled Record indicated the patch that was being destroyed was the same patch that had been removed from the medication cart for administration. She acknowledged the missing dates and times of the destruction of the fentanyl patches. 8. Review of the provider's 1/18/25 Drug Diversion	F0755		

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F0755 SS = D	Continued from page 116 Prevention policy revealed, "Medications classified by the Drug Enforcement Administration (DEA) as controlled substances are subject to special handling, storage, disposal, and record keeping". "Administration of transdermal controlled substances should follow the above for documentation of administration, as well as: i. Placement of patches will be checked and documented on the MAR every shift. ii. Removal and destruction of controlled substance transdermal patches requires two nurses with appropriate documentation on the specific inventory sheet." "During destruction of controlled substances, the inventory sheet of specific medications will be evaluated for signs of potential diversion, such as borrowing, consistent administration by one nurse, inappropriate documentation, etc."	F0755		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure a medication error rate of less than 5 percent related to a lidocaine patch (a topical pain-relieving patch) was removed as prescribed for one of one observed resident (30) by licensed practical nurse (LPN) SS and sucralfate (a medication used to treat and prevent ulcers) was administered before the noon meal as prescribed for one of one observed resident (19) by LPN KK. Those observed errors resulted in a medication error rate of 7.41%. Findings include: 1. Observation, interview, and medication administration (MAR) review on 4/28/26 at 8:51 a.m. with LPN KK while she applied a lidocaine patch to resident 30's lower back revealed she brought the lidocaine patch into resident 30's room. When she lifted the back of resident 30's shirt to apply the lidocaine patch, LPN KK stated there was a patch on her lower back. She removed the lidocaine patch	F0759	1. Resident #30's lidocaine patch was immediately removed upon identification that the previous patch remained in place despite documentation indicating removal. The physician and responsible party were notified per facility policy and a medication error report was completed and reviewed. Resident #19's physician-ordered sucralfate administration timing was reviewed with licensed nursing staff to ensure administration prior to meals as ordered. The physician and responsible party were notified per facility policy and a medication error report was completed and reviewed. All residents were identified as having the potential to be affected by the deficient practice. Identified nurses were contacted by the DON and educated regarding the findings. A facility-wide audit was completed for residents receiving topical patches requiring scheduled removal and residents receiving medications ordered before meals, with meals, after meals, or at bedtime to verify medication administration records and medication administration practices reflected physician orders accurately. Any deficient findings identified during the audit process were corrected immediately. 2. The facility reinforced medication administration oversight processes to ensure medications are administered and documented according to physician orders, including timely removal of topical patches and compliance with	6/2/2026

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F0759 SS = D	Continued from page 117 which was dated "4/27" and applied the new patch. LPN KK stated she needed to look at resident 30's physician's order because lidocaine patches are usually applied for 12 hours and then removed. LPN KK reviewed the order and stated the physician's order in resident 30's MAR indicated the patch was to be removed as scheduled. She then verified it was documented as removed on 4/27/26 at 6:59 p.m. by LPN SS. LPN KK stated she would notify director of nursing (DON) B that the lidocaine patch was not removed as documented on 4/27/26. 2. Review of resident 30's electronic medical record (EMR) revealed she had an 8/29/25 physician's order for a lidocaine external patch 4% to be applied to her lower back one time a day for pain and remove the patch as scheduled. The order in the MAR scheduled the removal of the patch for 6:59 p.m. 3. Observation and interview on 4/28/26 at 2:11 p.m. with LPN KK while she administered medications to resident 19 revealed LPN KK prepared acetaminophen and sucralfate to be administered by mouth and one topical pain relief gel. The pain relief gel and the acetaminophen were scheduled to be administered three times per day and were due to be administered. The sucralfate was scheduled to be administered before meals and at bedtime. LPN KK stated she did not realize that resident 19 had a medication she was supposed to receive prior to the noon meal. 4. Review of resident 19's EMR revealed she had a 3/7/23 physician's order for sucralfate one gram before every meal and at bedtime for gastro-esophageal reflux disease (heartburn). 5. Interview on 4/28/26 at 2:31 p.m. with LPN N revealed medications were expected to be administered within one hour before or one hour after their scheduled times. If a medication error was discovered the person who discovered the medication error was to notify the DON and the DON would complete the medication error report. She stated that only managers completed medication error reports. 6. Interview on 4/29/26 at 8:24 a.m. with registered pharmacist JJ revealed sucralfate was ordered to be	F0759	medication timing requirements. Nursing management will review medication administration records, patch application and removal documentation, and timing-specific medication administration practices to verify compliance with physician orders. A new system was implemented requiring medication pass competency observations for licensed nurses within 30 days upon hire, annually and as needed. DON or designee educated licensed nursing staff regarding the Five Rights of Medication Administration, accurate medication administration documentation, patch removal requirements, medication timing requirements, and medication error identification and reporting by 6/2/2026. Staff not in attendance will receive education prior to their next scheduled shift. 3. DON/designee will audit 5 resident samples weekly for 4 weeks, then monthly for 2 additional months, to observe medication passes, verify topical patch removal documentation, and review administration timing documentation for medications ordered with specific meal-related instructions. Audit findings will be reviewed monthly in QAPI meeting for further recommendations and ongoing compliance.	

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F0759 SS = D	Continued from page 118 administered before meals because it was meant to coat the stomach and if there was food in the stomach it may not be as effective. 7. Interview on 4/29/26 at 10:09 a.m. with DON B revealed she expected that when a medication error was identified, the staff member would report the medication error to her. She would complete the medication error report. The nurse was responsible for notifying the resident's physician and representative of the medication error and enter the medication error into the computer under risk management (an internal tracking system). The risk management form was the only medication error form the nurses had access to. DON B verified that LPN KK had notified her of the lidocaine patch that was not removed from 30's lower back on 4/27/26. DON B stated she started a medication error report for the lidocaine patch that was not removed as it was documented to have been. She expected medications to be administered to the resident within one hour before or after the medication was scheduled to be administered. She expected medications that were scheduled to be administered before meals would be administered before the meal. 8. Review of the provider's December 2019 Medication Administration-General Guidelines policy revealed the "FIVE RIGHTS- Right resident, right drug, right dose, right route and right time, are applied for each medication being administered." "Medications are administered withing [60 minutes] of scheduled time, except before, with or after meal orders, which are administered [based on mealtimes]." 9. Review of the provider's 5/14/25 Medication Errors policy revealed "Each medication error discovered will be documented on the Medication Error Report form. The person discovering the error will complete Part 1 of the Form." "Part 3 of the Form will address how this error occurred and can be prevented in the future. This section will be completed by the nurse/medication aide most closely responsible for the error."	F0759		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F0761	1. Influenza vaccines stored in the second medication room refrigerator were immediately removed and destroyed per facility policy. The second refrigerator was removed from the medication room on 4/30/2026 by the	6/2/2026

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F0761 SS = D	Continued from page 119 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure the temperature was monitored in one of two sampled refrigerators in one of one medication room that had influenza vaccines stored in it and two of two observed glucometer test strip containers with a shortened expiration date (supplies that, after opening, expire before the manufacturer's expiration date) were dated when they were opened. Findings include: 1. Observation and interview on 4/27/26 at 12:53 p.m. with registered nurse (RN) D in the medication room revealed there were two refrigerators in the medication room. The first refrigerator contained various medications. The second refrigerator had four boxes of influenza vaccine. When the refrigerator temperature monitoring log was requested RN D produced the log for the refrigerator with multiple medications listed on it. She stated the second refrigerator's temperature was not monitored. It was the refrigerator they used	F0761	Maintenance Director and Regional Nurse Consultant. Open glucometer test strip containers identified without open dates were discarded, replaced, and dated appropriately. All residents were identified as having the potential to be affected by the deficient practice. A facility-wide audit was completed by nursing leadership to verify medication refrigerators contained thermometers, temperature documentation logs were present and completed appropriately, and opened glucometer test strip containers were dated according to manufacturer instructions. Any deficient findings identified during the audit process were corrected immediately. 2. Spare refrigerator was placed into usage during flu season without proper temperature log. Nursing or designee will review all opened glucometer test strips to ensure containers are dated immediately upon opening. Spare refrigerator removed. DON or designee educated licensed nursing staff regarding monitoring manufacturer instructions for glucometer test strips by 6/2/2026. Staff not in attendance will receive education prior to their next scheduled shift. 3. DON/designee will audit 5 medication storage areas weekly for 4 weeks, then monthly for 2 additional months, to verify opened glucometer test strips are dated according to policy and manufacturer instructions. Audit findings will be reviewed monthly in QAPI meeting for further recommendations and ongoing compliance.	

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F0761 SS = D	Continued from page 120 for their specimens collected from residents that needed to be sent for testing. She verified there were influenza vaccines in the second refrigerator and that the refrigerator was occasionally used for overflow of medications when the first refrigerator became too full. There were no specimens in the second refrigerator. 2. Observation and interview on 4/28/26 at 11:10 a.m. with licensed practical nurse (LPN) N in the medication room revealed there were four boxes of influenza vaccine in the second refrigerator. The date those boxes were dispensed from the pharmacy was 10/6/25 and the influenza vaccine labels indicated the vaccine was to be stored between 36 and 46 degrees Fahrenheit (F). There was no thermometer in the refrigerator. LPN N thought the influenza vaccines may have been put in that refrigerator because the other refrigerator was too full. She verified that the temperature of that refrigerator was not monitored, and it was used for specimen storage in the past, but she had not seen it used for that in there for a long time. 3. Observation on 4/21/26 at 8:32 a.m. in resident 47's room revealed she had a blue plastic container on her over-the-bed table. In the container was a glucometer (a machine used to check blood sugar levels) and glucometer test strips. The bottle of glucometer test strips was partially empty. There was no date documented on the bottle to indicate when the bottle had been opened, to determine when it would expire. 4. Observation and interview on 4/28/26 at 11:00 a.m. with LPN N in resident 32's room revealed LPN N removed a glucometer and a glucose test strip from a plastic container at resident 32's bedside. LPN N checked resident 32's blood sugar level with that glucose test strip and glucometer. There was no date to indicate when the container of glucose test strips had been opened, to determine when it would expire. LPN N verified there was not a date on the container of glucose test strips. She stated she did not date glucose test strips when she opened them, she referred to the manufacturer's expiration date to determine when they expired and needed to be disposed of. She did not know if glucose test strips had a shortened expiration date after they were opened. She stated she would have to ask the director of nursing (DON).	F0761		

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F0761 SS = D	Continued from page 121 5. Interview on 4/29/26 at 10:09 a.m. with DON B and regional nurse consultant C revealed the refrigerators in the medication room were used to store vaccines and medications. All refrigerator temperatures were to be monitored to ensure the temperature of the refrigerator was maintained at a safe storage temperature. Regional nurse consultant C stated she had been in the medication room recently and verified that there were influenza vaccines stored in the second refrigerator. Neither she nor DON B was aware that the temperature of that refrigerator was not being monitored. They expected the temperature of the refrigerators in the medication room to be monitored to ensure safe storage of medications and vaccines. DON B expected glucose test strips to be dated when they were opened because they would outdate before the manufacturer's expiration date once they were opened. DON B did not know how long after opening the glucose test strips were able to be used before they needed to be disposed of. Regional nurse consultant C verified the glucose test strips needed to be disposed of 30 days after they were opened. 6. Review of the provider's January 2018 Medication Storage In The Facility policy revealed, "Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier." "All medications are maintained within the temperature ranges noted in the United States Pharmacopeia (USP) and by the Centers for Disease Control (CDC)... Refrigerated at 36 [degrees] F to 46 [degrees] F (2 [degrees] C [Celsius] to 8 [degrees] C) with a thermometer to allow temperature monitoring." 7. Review of April 2015 UltrTRAK Complete Blood Glucose Test Strips manufacturer's instructions revealed, "Test strips expire 3 months after first opening. Write the first opening date on the test strip vial when you first open it."	F0761		
F0806 SS = D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides-	F0806	1. Resident #22's dietary preferences were reviewed with the resident, Dietary Manager, nursing staff, and care team. The resident's meal ticket, dietary profile, and care plan were reviewed and updated to accurately reflect food dislikes and substitute preferences, including no fish, no chicken, and no whole/chunked	6/2/2026

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F0806 SS = D	Continued from page 122 §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the provider failed to ensure that staff honored one of one sampled resident's (22) meal choice preferences for one of four observed meals. Findings include: 1. Observation on 4/21/26 at 12:08 p.m. in the dining room revealed licensed practical nurse (LPN) V reading the noon meal options aloud to resident 22, who said he did not like the fish being served that day and would rather have a hamburger. LPN V wrote on his meal ticket and left the dining room. At 12:19 p.m. resident 22 was served a plate containing fish. As LPN V walked past him, he told his tablemate, "I don't want fish." LPN V stopped at the table and said, "If you don't fill out your menu you get what they're serving." The resident left the dining room a few moments later, without eating the fish. 2. Interview on 4/21/26 at 1:47 p.m. with resident 22 revealed that his meal ticket and care plan included his preference for no fish. He said, "I have it right there on the menu what I like and don't like, and I said no fish. I keep telling them, but they keep bringing it to me." He said LPN V had helped him request a hamburger at lunchtime, but that staff brought him fish instead. 3. Interview on 4/21/26 at 2:15 p.m. with resident 22's family member revealed that he did not like fish, chicken, or tomatoes, "but they always put that stuff on his plate." She stated that resident 22 would leave the dining room hungry if they served food he did not like. 4. Interview on 4/22/26 at 2:51 p.m. with dietary manager (DM) CC revealed that residents could	F0806	tomatoes. All residents were identified as having the potential to be affected by the deficient practice. A facility-wide audit of dietary preference documentation was completed to verify meal tickets, dietary profiles, and care plans accurately reflected resident food preferences, dislikes, allergies, and substitute meal options. Any deficient findings identified during the audit process were corrected immediately. 2. A new system was implemented requiring review and verification of dietary preferences within the EMR, care plans, meal tickets, and dietary profiles to ensure consistency across departments and accurate communication of meal substitutions during tray service. Beginning 5/13/2026, all staff were re-educated by the Administrator or designee regarding resident related to meal choice, substitute meal availability, honoring resident preferences, tray accuracy, and respectful communication regarding meal requests. Staff not in attendance will receive education on their next scheduled shift. Managers conducting meal observations will monitor resident satisfaction and plate accuracy during meal service. 3. Administrator/designee will complete meal service audits weekly for 4 weeks, then monthly for 2 additional months, to review meal tray accuracy, resident preferences, substitute meal availability, consistency between care plans and meal tickets, and resident satisfaction during meal service. Audit findings will be reviewed monthly in QAPI meeting for further recommendations and ongoing compliance.	

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F0806 SS = D	Continued from page 123 request substitution food items from an "always available" menu that included a variety of soups, sandwiches, hamburgers, and chicken strips. She said if a resident was not happy with the meal they received, she expected staff to offer substitute items from that menu. She was aware that resident 22's meal ticket included a preference for no chicken, fish, or tomatoes. 5. Interview on 4/22/26 at 3:04 p.m. with social services designee (SSD) J revealed that managers monitor mealtimes to make sure the residents' diet orders and preferences were accommodated. SSD J said residents were encouraged to submit alternative meal requests up to two hours before mealtimes, but residents could also request substitutions during the meal. Staff serving the food should cross-check the request with the resident's meal ticket. She stated, "If I know a resident doesn't like chicken or fish, for example, when I'm [the] manager on duty I will ask him what he wants instead." She stated she was aware that resident 22 did not like chicken, fish, or tomatoes, and she expected that the managers on duty would help ensure he received food he liked. 6. Interview on 4/27/26 at 12:03 p.m. with CNA DD revealed that staff serving meals should check a resident's meal ticket to ensure order accuracy. She stated that if the order was wrong, "we take the plate back or set it off to the side, then go ask the resident what they want instead." 7. Interview on 4/27/26 at 2:34 p.m. with cook OO revealed that residents' dietary preferences were added to their meal tickets upon admission to the facility. Residents received tickets for each meal and crossed off menu items they did not want, she said. An alternative menu was always available and that if a resident's preferences changed, she notified the DM to update their meal ticket. 8. Review of resident 22's 10/25/25 care plan revealed a dietary intervention dated 7/23/25 that read, "no fish, no chicken, and no whole/chunked tomatoes per my preferences." 9. Review of resident 22's 4/27/26 meal ticket revealed a note that read, "no fish, no chicken, and no whole/chunked tomatoes; dislikes: chicken, fish, fresh tomatoes."	F0806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435068	A. BUILDING B. WING	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA WATERTOWN	415 FOURTH AVE NE , WATERTOWN, South Dakota, 57201

(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
F0806 SS = D	Continued from page 124 10. Review of resident 22's medical record revealed nutrition assessments dated 1/9/26 and 10/10/25 where registered dietitian (RD) RR stated he prefers "no fish, no chicken, no whole tomato chunks...Recommend to continue to provide a well-balanced intake...according to diet order and preferences."	F0806		

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	435068	A. BUILDING 01 - BUILDING 0... B. WING	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA WATERTOWN	415 FOURTH AVE NE , WATERTOWN, South Dakota, 57201

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 4/22/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Watertown 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 K222, K223, K291, and K321 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0222 SS = D Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or	K0222	1. The cross-corridor 90-minute fire-rated exit doors outside the maintenance office were immediately evaluated by maintenance staff. The defective automatic flush bolt strike and door alignment issues preventing proper egress operation were repaired and adjusted to ensure the doors opened freely in the direction of egress within allowable force requirements. The doors were tested after repair to confirm proper latching and operation. All residents were identified as having the potential to be affected by the deficient practice. The Maintenance Director or designee completed a facility-wide audit of cross-corridor and fire-rated egress doors to ensure doors opened properly, latched appropriately, and met Life Safety Code requirements. Any deficient findings identified during the audit process were corrected immediately. 2. The Maintenance Director was educated regarding Life Safety Code requirements for egress doors, latching mechanisms, and inspection requirements by 6/2/2026. 3. Administrator or desginee will complete weekly audits of fire-rated and egress doors for 4 weeks, then monthly for 2 additional months, to ensure continued compliance with Life Safety Code	6/2/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lynna M. Speier	LNHA	5/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435068	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0222 SS = D Bldg. 01	Continued from page 1 is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to provide operable egress doors as required at one randomly observed exit door location (Fire doors outside maintenance office). Findings include: 1. Observation beginning on 4/22/26 at 11:00 a.m. revealed the cross-corridor, 90-minute fire-rated exit doors outside the maintained office were unable to be opened after they had been released from the magnetic hold open devices and latched. Testing of the door revealed it would not open without applying greater than fifty pounds of force in the direction of the path of egress. Further testing of those doors at	K0222	requirements. Audit findings will be reviewed monthly through the QAPI process for further recommendations and ongoing compliance.	

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K0222 SS = D Bldg. 01	Continued from page 2 that same time revealed the strike for the automatic flush bolt on the south leaf had worn a hole in the north leaf and would catch. That required the automatic flush bolt strike to be depressed from the back side for those doors to be re-opened. Interview with the maintenance director at the time of the observation confirmed those conditions. He stated he was unaware those doors could not be opened once latched. He further stated that today was his third day in the facility and while somebody had mentioned those doors had an issue, he was not aware of what it was and had not yet had time to figure it out.	K0222		
K0291 SS = D Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on observation, testing, interview and record review the facility failed to maintain emergency lighting on backup power for 2 of 2 battery powered emergency lights. Findings include: 1. Observation and testing on 4/22/26 at 11:10 a.m. revealed the battery powered emergency lights in the transfer switch room did not function when the test button was pressed. Interview with the maintenance director at the time of the observation and testing confirmed those conditions. He stated today was his third day in the facility and he was not yet fully trained on the requirements for battery powered emergency lights. Record review that same day revealed the facility could not provide documentation of either the monthly or annual battery test for that battery powered emergency light. 2. Observation and testing on 4/22/26 at 2:30 p.m. revealed the battery powered emergency lights in the generator room did not function when the test	K0291	1. The battery-powered emergency lights located in the transfer switch room and generator room were immediately repaired and/or replaced to ensure proper operation during power interruption. Functional testing was completed after corrective action. Missing monthly and annual testing documentation logs were initiated and updated. All residents were identified as having the potential to be affected by the deficient practice. The facility completed a facility-wide audit of battery-powered emergency lighting to ensure proper function and documentation of required monthly and annual testing. Any deficient findings identified during the audit process were corrected immediately. 2. The Maintenance Director was educated regarding NFPA emergency lighting inspection, testing, and documentation requirements by 6/2/2026. 3. The Administrator or designee will conduct and document monthly emergency lighting inspections and annual battery testing per NFPA requirements. Audit findings will be reviewed monthly through the QAPI process for 3 months for further recommendations and ongoing compliance.	6/2/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435068	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 04/22/2026

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K0291 SS = D Bldg. 01	Continued from page 3 button was pressed. Interview with the maintenance director at the time of the observation and testing confirmed those conditions. He stated today was his third day in the facility and he was not yet fully trained on the requirements for battery powered emergency lights. Record review that same day revealed the facility could not provide documentation of either the monthly or annual battery test for that battery powered emergency light. LSC 7.9.3.1.1 (3), 19.2.9.1.	K0291		
K0321 SS = D Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 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. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 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	K0321	1. The mechanical room corridor door was immediately repaired and adjusted to ensure the door self-closed and positively latched into the frame. Combustible storage within the mechanical room was reviewed and reorganized to maintain compliance with hazardous area requirements. All residents were identified as having the potential to be affected by the deficient practice. The facility completed a facility-wide audit of hazardous areas, including mechanical rooms, storage rooms, laundry rooms, and maintenance spaces, to ensure doors self-closed and latched properly and combustible storage requirements were maintained. Any deficient findings identified during the audit process were corrected immediately. 2. Maintenance staff and department managers were educated regarding hazardous area requirements, self-closing doors, latching mechanisms, and combustible storage practices by 6/2/2026. 3. Administrator or designee will complete weekly hazardous area audits for 4 weeks, then monthly for 2 additional months. Audit findings will be reviewed monthly through the QAPI process for further recommendations and ongoing compliance.	6/2/2026

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K0321 SS = D Bldg. 01	Continued from page 4 (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 (mechanical room) as required. Findings include: Based on observation and interview, the provider failed to maintain one randomly observed hazardous area (mechanical room) as required. Findings include: 1. Observation on 4/22/26 at 11:39 a.m. revealed the mechanical room was over 100 square feet and contained combustible items. The corridor door would not close and latch with the operation of the closer. Interview with the maintenance director at the times of the observations confirmed those findings. He stated today was his third day in the facility and he was not yet fully trained on the requirements for hazardous areas. The deficiencies affected two of numerous requirements for hazardous storage rooms.	K0321		
K0223 SS = C Bldg. 01	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	K0223	1. The laundry room door, nurse training room door, and short wing resident laundry/soiled room door were immediately repaired and adjusted to ensure all doors positively self-close and latch into the frame without obstruction. Door closers and alignment were adjusted as necessary. All residents were identified as having the potential to be affected by the deficient practice. The facility completed a facility-wide audit of corridors, smoke barrier, hazardous area, and self-closing doors to verify positive latching and proper operation. Any deficient findings identified during the audit process were corrected immediately.	6/2/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435068	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 04/22/2026

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K0223 SS = C Bldg. 01	Continued from page 5 * 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 equipped with self-closing devices (laundry room and nurse training room) were positively latching into their door frames. Findings include: 1. Observation and testing on 4/22/26 at 11:21 p.m. of the door from the laundry room into the corridor revealed that door was equipped with a closer, but it was not automatically latching into the door frame. That door appeared to be kept from fully latching into the frame by the pressure difference between that room and the corridor. 2. Observation and testing on 4/22/26 at 12:03 p.m. revealed the corridor door from the nurse training room was equipped with a closer, but it was not automatically latching into the door frame. That door appeared to hit its frame keeping it from latching. 3. Observation on 4/22/26 at 12:32 p.m. revealed the short wing resident laundry/soiled holding room was equipped with a closer, but it was not automatically latching into the door frame. That door's closer appeared to keep it from latching. Doors provided with closers are required to latch into their frames automatically. 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 today was his third day in the facility and he was not yet fully trained on the requirements for doors equipped with automatic closers.	K0223	2. Maintenance staff were educated regarding Life Safety Code requirements for self-closing and positive-latching doors by 6/2/2026. 3. Administrator or designee will audit self-closing and positive-latching doors weekly for 4 weeks, then monthly for 2 additional months. Audit findings will be reviewed monthly through the QAPI process for further recommendations and ongoing compliance.	

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K0223 SS = C Bldg. 01	Continued from page 6 Those deficiencies could affect 100% of the occupants of their smoke compartments.	K0223		

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	435068	A. BUILDING B. WING	04/22/2026

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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 4/22/26. Avantara Watertown 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	TITLE	(X6) DATE
Lynna M. Speier	LNHA	5/28/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10704	A. BUILDING: _____ B. WING _____	04/29/2026

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted on 4/21/26 through 4/23/26 and 4/27/26 through 4/29/26. Avantara Watertown was found in compliance.	S 000		

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

Lynna M. Speier | LNHA | 5/28/2026