STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 5/5/26. The area surveyed was quality of care related to a resident who was not secured by the whirlpool tub seatbelt and fell from the whirlpool tub chair, which resulted in a forehead laceration that required sutures. Eastern Star Home of South Dakota, Inc was found to have past non-compliance at F689.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to ensure an environment free from accident hazards by one of one certified nursing assistant (CNA)/bath aide (E) who did not use the required whirlpool chair safety belt while providing a whirlpool bath for one of one sampled resident (1) who subsequently fell out of the whirlpool chair onto the floor, which caused laceration to the resident's forehead that required sutures. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings included:	F0689	"Past Noncompliance - no plan of correction required"	

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
Deborah Bowar, Administrator, LPN	Administrator, LPN	05/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0689 SS = G	Continued from page 1 Review of the provider's 1/22/26 submitted SD DOH FRI report regarding resident 1 revealed that on 1/21/26 at 11:15 a.m. CNA/bath aide E radioed for immediate staff assistance to the whirlpool room. CNA F, charge nurse/licensed practical nurse (LPN) D, director of nursing (DON) B and Minimum Data Set (MDS) coordinator C immediately responded. Resident 1 was lying on the floor on his left side with his left arm tucked underneath him. CNA/bath aide E was sitting on the floor next to resident 1 applying pressure to his head. Charge nurse/LPN D assessed resident 1 and saw that he had a laceration to his forehead. Resident 1 demonstrated the ability to move both upper and lower extremities, a neurological examination (assessment of the residents brain, spinal cord, and nerve function) was completed, and his vitals (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) were obtained. CNA/bath aide E stated resident 1 had lost consciousness for less than one minute following the fall from the whirlpool chair. Resident 1 denied experiencing any nausea but reported having a headache. Resident 1 had advanced dementia, but he was able to respond to yes and no questions. The on-call provider was notified and resident 1 was to be transferred to the local hospital. Emergency medical services were called at 11:25 a.m., arrived at the facility at 11:35 a.m., left with resident 1 at 11:40 a.m. Resident 1 returned to the nursing home later that day. As part of the provider's investigation of the incident, CNA/bath aide E was interviewed and stated she was positioned behind resident 1 while attempting to reposition the whirlpool chair wheels to lock them. She raised the chair slightly and resident 1's feet were no longer able to touch the floor. Resident 1 had leaned forward and fell out of the whirlpool chair and onto the floor. CNA/bath aide E attempted to grab resident 1 from behind but was only able to slow his fall. Resident 1 fell on his left side and hit the left side of his forehead on the floor, resulting in the laceration. Resident 1 was not wearing the whirlpool chair safety belt at the time of the fall. CNA/bath aide E was removed from being a designated bath aide following the incident, DON B reviewed the facility's "Procedure for Whirlpool Bath Policy". CNA/bath aide E and all bath aides beginning on 1/21/26 and before their next scheduled shift.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0689 SS = G	Continued from page 2 2. Review of resident 1's medical record revealed he admitted to the facility on 4/10/25. His diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities). His 7/30/25 Brief Interview for Mental Status (BIMS) assessment score was 0, which indicated his cognition was severely impaired. Resident 1 passed away at the facility on 2/26/26. Resident 1's 1/21/26 discharge summary report from the local hospital revealed he received 12 sutures on his left frontal scalp. The sutures were 2.5 cm (centimeter) in length and .25 cm in width. The hospital staff applied bacitracin (an antibiotic ointment) and a sterile gauze dressing to resident 1's sutures and he was to follow up with medical director G at the nursing home in one week for a wound recheck and suture removal. A nursing progress note dated 1/28/26 indicated that medical director G requested resident 1's sutures remain in place for a few additional days. The 1/28/26 progress note indicated that the facility received orders for sutures to be removed on 1/30/26. 3. Phone interview on 5/5/26 at 11:46 a.m. with CNA/bath aide E regarding the above incident resident 1 revealed that she had just raised the whirlpool chair and was attempting to adjust the wheels to lock the chair's brakes when resident 1 leaned forward and fell out of the whirlpool chair and onto the floor hitting his head. CNA/bath aide E noticed he was bleeding and immediately applied pressure to the area with a towel. She stated she called out for help and she charge nurse/LPN D and CNA F were the first to respond. Charge nurse/LPN D replaced the bloody towel with a clean towel and applied pressure to resident 1's head while CNA F obtained the resident's vital signs. CNA/bath aide E stated that another staff member called 911. The staff remained with resident 1 in the whirlpool room until emergency services arrived and transported the resident to the hospital. CNA/bath aide E confirmed that she did not follow the facility's policy requiring the use of the whirlpool chair safety belt and did not use the safety belt with resident 1 at the time of the incident. She was removed from the bath aide work schedule and was had only recently permitted to work was a bath	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0689 SS = G	Continued from page 3 aide shift per work week. 4. Phone interview on 5/5/26 at 12:01 p.m. with charge nurse/LPN D revealed she was the charge nurse on duty on 1/21/26. She did not recall many details from that day; however, she remembered that upon arriving in the whirlpool room and observing resident 1 on the floor, she immediately recognized that emergency medical services needed to be contacted. She also recalled that resident 1 appeared more sluggish than usual following the fall. 5. CNA F was not available for an interview during the time of the survey. 6. Interview on 5/5/26 at 12:20 p.m. with DON B revealed that she was notified by CNA F regarding resident 1's fall in the whirlpool room. DON B stated that when she arrived, she saw charge nurse/LPN D holding resident 1's head and was informed that he fell from the whirlpool chair and MDS coordinator C had contacted emergency medical services. DON B stated resident 1 was alert and moved his upper and lower extremities. She stated that staff remained with resident 1 until emergency medical services arrived. DON B acknowledged that CNA/bath aide E did not follow the facility's "Procedure for Whirlpool Bath" policy and did not use the whirlpool chair safety belt at the time resident 1's fall. DON B stated resident 1 was declining over the prior few months due to his late-stage dementia. 7. Interview on 5/5/26 at 12:30 p.m. with MDS coordinator C revealed that her office was located next to the whirlpool room. Regarding the above incident involving resident 1 she heard commotion coming from that area and went to check on what was happening. When she entered the whirlpool room, she asked whether emergency medical services needed to be called and was instructed to do so. After contacting emergency medical services, she returned to the whirlpool room to offer any additional assistance while the staff remained with resident 1 until the emergency medical services arrived. 8. Review of the provider's undated Procedure for Whirlpool Bath policy revealed that bath aides were to ensure, "With resident properly secured with belting, facing the deck of the rub [tub], raise the transfer to the appropriate height to clear the top of	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0689 SS = G	Continued from page 4 the seat inside the tub," and " Keep [the] bath chair belt on until [the] resident is ready to transfer." 9. Review of the provider's undated Bath Aide Responsibilities policy revealed that the bath aides were required to ensure that, "All residents will be properly secured with belting." 10. The provider's implemented actions to ensure that the deficient practice does not reoccur were verified on 5/5/26 after record reviews and interviews revealed that the facility had followed its quality assurance and performance improvement (QAPI) process regarding quality of care and all bath aides were education on the Procedure for Whirlpool Bath policy beginning on 1/21/26. If the staff could not attend, they were expected to review the information and acknowledgement sign the sheet before their next scheduled shift. Interviews indicated the staff understood the information provided regarding the use of the whirlpool chair safety belt. Ongoing audits of the whirlpool safety chair belt were conducted and the audits results are planned to be reported to the quality assurance committee at their scheduled monthly meetings for six months for review and recommendations. Based on the above information, the non-compliance at F689 occurred on 1/21/26, and based on the provider's 1/22/26 corrective actions implemented for the deficient practice confirmed on 5/5/26, the non-compliance is considered past non-compliance.	F0689		