STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA HURON	1345 MICHIGAN AVENUE SW , HURON, South Dakota, 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/8/26 through 3/12/26. Avantara Huron was found not in compliance with the following requirements: F600, F609, F610, F641, F644, F655, F657, F684, F710, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/8/26 through 3/12/26. Areas surveyed included allegations of potential resident abuse, resident rights, and resident safety related to an elopement and a resident who fell. Avantara Huron was found not in compliance with the following requirements: F600, F609, F610, and to have past noncompliance at F689.	F0000		
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 the South Dakota Department of Health (SD DOH) complaint report, interview, document review, record review, and policy review, the provider failed to	F0600	1.Resident 57's allegation of sexual abuse was reported to the South Dakota Department of Health (DOH), Beadle County Sheriff's Department, Dakota at Home, her power of attorney (POA), and provider on 3/11/26. Resident 57 refused skin assessment on 3/11/26. Her previous skin assessment was completed by registered nurse (RN) on 3/5/26 with no skin alterations or other injuries noted. Resident 57 was offered counseling services on March 12, 2026. Certified Nursing Assistant (CNA) D was immediately suspended upon notification of allegation on 3/11/26. Resident 78's allegation of sexual abuse was reported to the DOH, Beadle County Sheriff's Department, Dakota at Home, and the facility Medical Director on 3/11/26. Resident 78 was discharged from the facility on 12/8/25. No immediate corrective action could be taken to ensure no injury occurred. Certified Occupational Therapy Assistant (COTA) and Social Service Designee (SSD) were immediately suspended on 3/11/26 for failure to report an allegation of sexual abuse. The above immediate corrective actions occurred upon discovery of the allegations during the DOH annual recertification/complaint survey. On 3/11/26, Nurse Managers completed interviews with all cognitive residents that have a Brief Interview for Mental Status (BIMS) score of 12 or greater, this included 32 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 completed interviews with all staff working evening and night shift on 3/11/26 to determine if a resident has ever reported that they had been	April 14, 2026

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F0600 SS = SQC-J	Continued from page 1 protect the resident's right to be free from sexual abuse by one of one certified nursing assistant (CNA) (D) for one of two sampled resident (57) who reported she was touched in a private area without her consent. And by one of one unidentified staff member for one of two sampled resident (78) who reported she was touched in a private area without her consent. Immediate Jeopardy (IJ) at F600, severity J., began on 3/11/26 at 11:40 a.m. when resident 57 revealed in an interview that she had a concern about being touched by a staff member on 1/23/26 during the night rounds. Resident 57 reported that certified nursing assistant (CNA) D had pulled back the blankets and checked her incontinence (involuntary urine or bowel leakage) brief by touching her. She was unsure whether it was on the inside or outside of her brief, which startled her. Resident 57 reported this concern to registered nurse (RN) H on 1/23/26. The facility failed to recognize the resident's concern as a potential abuse situation and failed to implement immediate measures to protect all residents within the facility following resident 57's allegation of abuse. The facility failed to report and thoroughly 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 57 and all the residents to prevent similar situations from occurring. Review of a SD DOH complaint report revealed that resident 78 had reported an allegation of inappropriate touching to her perineal area by an unidentified female staff member that occurred between 11/6/25 and 12/8/25 during the night shift. Resident 78 no longer resided at the facility. While she resided there the resident reported her allegation to certified occupational therapy assistant (COTA) E. Interview on 3/11/26 at 1:20 p.m. with COTA E confirmed the resident had reported the allegation to her and COTA E transported resident 78 to report it to social service designee (SSD) F. Interview on 3/11/26 at 1:45 p.m. with SSD F revealed she denied knowledge of the resident's allegation of being touched inappropriately by a staff member. Further interviews on 3/11/26 at 3:10 p.m. with administrator A and director of nursing (DON) B confirmed there was no documentation to support any other allegations had been reported or investigated as a potential abuse situation.	F0600	touched inappropriately, whether they have ever witnessed a staff member touching a resident inappropriately, and if they know who to report abuse concerns to. Director of Nursing (DON) or designee completed 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 to report abuse concerns to. All interviews were completed as of March 17, 2026. 2.The Administrator, DON, and interdisciplinary team (IDT), which includes, two clinical care coordinator nurses, one MDS nurse coordinator, one IP nurse, dietary manager, activity department director, environmental services director, social services designee, in collaboration with the governing board and medical director reviewed the Abuse and Neglect policy and procedures to ensure residents are free from abuse. The policy and procedures do address care techniques for residents, including inappropriate staff-to-resident interactions that constitute abuse, timely reporting of all allegations of abuse to all applicable entities, timely notifications to all applicable parties, and processes to ensure complete and thorough investigation to mitigate the risks of future abuse. The Administrator, DON, or a Nurse Manager are educating all staff and contract staff on the Abuse and Neglect policy and procedures to ensure residents are free from abuse. The education includes inappropriate staff-to-resident interactions that constitute abuse, timely reporting of all allegations of abuse to all applicable entities, timely notifications to all applicable parties, and processes to ensure complete and thorough investigations to mitigate the risks of further abuse. DON or designee will educate all nursing staff and contract staff on appropriate approach and care techniques for checking a brief used for incontinence to maintain resident's psychosocial well-being and safety. Additionally, the DON or designee will complete a competency on abuse and neglect for all staff and contracted staff, as well as competency on appropriate approach and care technique when checking residents for incontinence for all nursing and contracted nursing staff. Education and competencies will occur no later than April 14, 2026, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. Education will be ongoing for all new staff. 3.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. DON or designee will interview 5 residents to ensure staff are checking them for incontinence appropriately to maintain their psychosocial well-being and safety. 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 incontinent care.	

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F0600 SS = SQC-J	Continued from page 2 Administrator A was notified of the IJ on 3/11/26 at 6:52 p.m. and a removal plan as requested. The removal plan was received on 3/12/26 at 12:58 a.m. by email. The edited removal plan was received on 3/12/26 at 7:31 a.m., and it was accepted on 3/12/26 at 8:35 a.m. The IJ was removed on 3/12/26 at 9:35 a.m. as confirmed by onsite verification by the survey team. After the IJ removal, the severity of the non-compliance remained at a G. The current census was 71. Findings include: 1. Review of the complaint report submitted to the SD DOH on 2/6/26 revealed "that either a student or an aide had stuck their hands down her [resident 78's] pants to check if she was dry, without her permission. She stated her mind is good, and she had told the person that she didn't need to go to the toilet, and that she was dry. The aide or student proceeded to 'check' her without asking. She felt very embarrassed by this. She stated she spoke with facility management the next day, and they verified the person should not have done that. There was no further follow-up with the resident." She could not recall the name of the person who had done it, and the incident bothered her. 2. Interview on 3/10/26 at 12:21 p.m. with DON B revealed that an internal investigation was completed after resident 57 complained to RN H that a staff member checked her incontinence brief to see if it was wet, which startled her since she was independent with using the bathroom. RN H reported that to DON B. DON B explained that CNA D did not mean it in a sexually inappropriate way so she did not report the incident to the SD DOH. The incident happened on 1/23/26 during the night shift rounds. She stated CNA D currently worked at the facility and she disciplined and educated CNA D after the incident. She stated that resident 57's pocket care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) was updated, and the staff who cared for her reviewed that. She thought the CNAs that read that were educated on the changes to her care plan. She did not have a signature sheet to verify	F0600	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 and Medical Director at monthly Quality Assurance Performance Improvement (QAPI) for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	

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F0600 SS = SQC-J	Continued from page 3 that staff education regarding resident 57's abuse allegation was completed. She acknowledged that touching a resident's incontinence brief was not an acceptable way to see if they were incontinent. She said the investigation report she completed indicated that resident 57's brief was not checked by touching her. If CNA D had touched the brief to see if it was wet, DON B would have reported it to the SD DOH, and CNA D would have been suspended until the investigation was completed, and possibly had his employment at the facility terminated. No audits were completed after the incident occurred to ensure it would not occur again. DON B told resident 57's daughter about the incident and asked her daughter to notify them if resident 57 brought it up. The investigation documentation stated SSD F had followed up with resident 57 a few days after the incident. 3. Review of the provider's internal investigation form revealed that resident 57's abuse allegation was reported on 1/23/26 to RN H by resident 57 and stated "the night aide came in her room and pulled back her blanket and checked her brief which had startled her. [RN H] reported that [resident 57] did not feel that this was completed inappropriately towards her, but more of a lack of education." RN H reported this to DON B, and DON B had SSD F "conduct a social service visit to discuss the incident with [resident 57]." Review of SSD F interview documents that were attached to the internal investigation form revealed it stated, "I spoke with [resident 57] about what happened and checked on how she was feeling about the situation. [Resident 57] reported that staff entered her room during the overnight rounds while she was sleeping and she was not expecting someone to come in at that time. The CNA pulled down her blanket to check her brief which startled her. [Resident 57] and I talked about how the CNA was completing routine rounds and may not have known her usual nighttime routine. [Resident 57] stated she understood and said she does not believe the CNA meant anything inappropriate towards her. She also stated she is not upset with the CNA and felt he likely did not know her routine. I stayed with [resident 57] for a while and we continued to talk about the	F0600		

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F0600 SS = SQC-J	Continued from page 4 situation. During the visit she appeared calm and comfortable with discussing what happened. She did not express ongoing concerns. I asked if she would like me to notify family and she declined. Social Services will continue to monitor and remain available if she has any concerns. [Resident 57] reports that she feels safe at the facility." On 1/26/26 SSD F interviewed resident 57 regarding the incident, and it stated "[Resident 57] reported that she has had no further issues. She remains to feel safe at the facility." On 1/27/26 SSD F interviewed resident 57 regarding the incident, and it indicated that resident 57 had no further issues, felt safe, and she would notify SSD if she had further issues. The outcome of the investigation summary section described the incident that had occurred. It stated that administrator A and DON B called resident 57's daughter to notify her of the incident, and her daughter said she would call them if resident 57 said anything about it. It stated that DON B interviewed CNA D on 1/23/26, and he reported that he said the resident's name before pulling the resident's blankets back. He thought she knew what he was doing, and he apologized that he startled her. DON B gave him a written warning. DON B told resident 57 that her care plan was changed, and the investigation summary indicated that resident 57 was happy with that. It stated, "In review of South Dakota's reporting guidelines this did not rise to the level of abuse/neglect due to [resident 57's] denial of inappropriate action towards her and [CNA D's] lack of touching her and therefore was not reported to the Department of Health." 4. Interview on 3/11/26 at 11:15 a.m. with SSD F revealed that CNA D touched the resident's incontinence brief to see if she was wet. SSD was unsure if resident 57's incontinence brief or private area was touched when CNA D checked her for incontinence. She verified that it was not an appropriate way to see if a resident was incontinent. 5. Interview on 3/11/26 at 11:40 a.m. with resident 57	F0600		

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F0600 SS = SQC-J	Continued from page 5 revealed that the CNA touched her on the inside of her incontinence brief. She became tearful, and by the end of the interview she was not sure if she was touched on the inside or the outside of her incontinence brief, and she just wanted to forget about it. 6. Interview on 3/11/26 at 9:08 a.m. with RN H revealed that during a night shift, a CNA was confused about which residents needed to be checked for incontinence, and that the residents down the D wing were startled by this. The CNA still worked here, and she was not aware whether he continued to do that, and no residents had complained about that. 7. Interview on 3/11/26 at 12:50 p.m. with independent living specialist QQ regarding resident 78's complaint about a female staff member who put her hands down resident 78's pants to feel if she was wet, revealed resident 78 was no longer at the facility. Resident 78 was just there for rehab and at the time of the incident, she was independent with toileting. The incident made resident 78 feel uncomfortable and she reported to independent living specialist QQ that she had nightmares about it and recalled resident 78 saying got an "eerie gross feeling" about it. Independent living specialist QQ continued to stay in contact with her. She was not sure who resident 78 reported the incident to at the facility, but said resident 78 made a formal complaint, and she did not hear back from anyone about it. Independent living specialist QQ was unsure when the incident occurred. 8. Phone interview on 3/11/26 at 12:58 p.m. with resident 78 revealed she was unsure when the incident occurred, but she was able to recall that it happened during a night shift. The female staff member asked her if she needed to use the bathroom, and when resident 78 said no, the female staff member put her hand down resident 78's pants and said, "Nope, you're dry". Resident 78 reported that she had resided in the D wing, she wore her own underwear, and that a female staff member put her hand on the inside of her underwear when she checked her. She said she did not do anything about it that night, but the next day, she told COTA E about it. Resident 78 reported that COTA E brought her to SSD F's office for her to report the incident to SSD F. She	F0600		

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F0600 SS = SQC-J	Continued from page 6 said she reported the incident to the two women in that office, and said they had looked surprised. When she was telling them what happened, she thought it appeared that SSD F was looking at the staffing schedule to see who was working that night. Resident 78 was told that they had students from a vocational school there at the facility. Resident 78 stated that she had made a formal complaint with SSD F and the other lady that was in the office, and when she read her discharge paperwork from the facility, she did not see anything about the incident, so she made a complaint report with the SD DOH so it would not happen to other residents. She said no one from the facility followed up with her after she made the formal complaint. 9. Interview on 3/11/26 at 1:20 p.m. with COTA E revealed that resident 78 told her about the incident that occurred during the night shift, where a staff member put their hands in resident 78's pants to see if she was incontinent. COTA E reported that resident 78 was upset and that she was sleeping when that staff member came into her room. She said she took resident 78 directly to the social services office, and SSD F was there, but she was unsure if anyone else was in there. COTA E stated that was not the first time residents had reported this concern to her. She was not sure how many residents had, but thought five or less, in the last six months. Residents reported to her that the staff ripped off their blankets and would feel around to see if they were incontinent. It happened to the residents who were both continent and incontinent. She listed two other residents who were still in the facility, who she recalled having that happen to. 10. Interview on 3/11/26 at 1:45 p.m. with SSD F revealed that she did not recall COTA E bringing resident 78 to her office or that resident 78 made a formal complaint to her. She reported that the therapy department brought the residents to her office frequently about "this or that". She stated that their process for filing resident grievances was to listen to them, document the grievance, investigate them, and report them to the SD DOH if needed.	F0600		

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F0600 SS = SQC-J	Continued from page 7 SSD F said that she did not recall any other residents, besides resident 57, reporting that staff put their hands in their pants to check if they were incontinent and stated, "it's a pretty serious thing." She said that and incident like that would be reported to administrator A and DON B for them to investigate it. Regarding resident 57, she stated she wrote her follow-up notes in a notebook, which she no longer had, and did not document about it in the electronic medical record (EMR). She said she did not talk to other staff or residents to see if a similar incident occurred with them. She said she visited with resident 57, but no other counseling was offered to her. When she talked to resident 57 about the incident, she told SSD F that she was embarrassed about it. 11. Interview on 3/11/26 at 2:27 p.m. with SSD G revealed that she did not recall any complaints regarding staff putting their hands down residents' pants to check to see if they were incontinent, and she did not recall COTA E bringing resident 78 to her office. If she were to receive a resident grievance, she was to document it on a form and turn it in to administrator A. 12. Interview on 3/11/26 at 3:10 p.m. with DON B revealed she only received a complaint from resident 57 regarding staff putting their hands in her pants to check to see she was incontinent. If a resident had a complaint concerning abuse allegations, she would investigate it. If the investigation determined that the staff were inappropriate, then she would report it to the SD DOH. She stated that their grievance process depended on the situation. They had grievance forms to fill out, but if she completed an internal investigation, she did not need to fill out the grievance form. Regarding the incident that involved resident 57, she interviewed RN H and the other night nurses about CNA D, but she did not document those interviews. She did not interview other residents to see if there was a similar incident that had happened to them. Mental health services were not offered to resident 57.	F0600		

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F0600 SS = SQC-J	Continued from page 8 13. Interview on 3/11/26 at 5:00 p.m. with administrator A and DON B revealed that they were not aware that resident 57 had was touched to check to see if she was incontinent. DON B had SSD F visit with resident 57 regarding the incident, and she thought resident 57 told SSD F that CNA D did not touch her. She explained how she updated the pocket care plan and that she talked with CNA D, provided him with education, and wrote him up. She stated that no other residents were interviewed. Administrator A stated that allegations of sexual abuse were to be reported to the SD DOH within two hours, reported to law enforcement, and Dakota at Home. She expected staff not to put their hands in the residents' incontinence briefs or touch the brief to check if the resident was incontinent. The incontinence brief had lines on it that turned color when it was wet, and the staff were to let the residents know what they were going to do and get their permission before they did anything. If a resident did not want to be checked, the staff were to report it to the charge nurse. 14. On 3/11/26 at 6:52 p.m., administrator A was notified of the IJ. On 3/12/26 at 12:58 a.m., the removal plan was received by email. On 3/12/26 at 7:31 a.m., the edited removal plan was received, and on 3/12/26 at 8:35 a.m., it was accepted. REMOVAL PLAN: "1. Resident 57's allegation of sexual abuse was reported to the South Dakota Department of Health (DOH), Beadle County Sheriff's Department, Dakota at Home, her power of attorney (POA), and provider on 3/11/26. Resident 57 refused skin assessment on 3/11/26. Her previous skin assessment was completed by registered nurse (RN) on 3/5/26 with no skin alterations or other injuries noted. Resident 57 will be offered counseling services. Certified Nursing Assistant (CNA) D was immediately suspended upon notification of allegation on 3/11/26. Resident 78's allegation of sexual abuse was reported to the DOH, Beadle County Sheriff's Department, Dakota at Home, and the facility Medical Director on 3/11/26. Resident 78	F0600		

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F0600 SS = SQC-J	Continued from page 9 was discharged from the facility on 12/8/25. No immediate corrective action could be taken to ensure no injury occurred. Certified Occupational Therapy Assistant (COTA) and Social Service Designee (SSD) were immediately suspended on 3/11/26 for failure to report an allegation of sexual abuse. 2. On 3/11/26, Nurse Managers completed interviews with all cognitive residents that have a Brief Interview for Mental Status (BIMS) score of 12 or greater, this included 32 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 completed interviews with all staff working evening and night shift on 3/11/26 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. 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 to report abuse concerns to. 3. Senior 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 3/11/26. 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 3/11/26. Nurse Managers educated all staff working the evening/night shift on 3/11/26 on the Abuse and Neglect policy, including immediate reporting and investigating, to ensure all residents remain free from abuse and/or neglect. Admin [administrator], 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	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

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F0600 SS = SQC-J	Continued from page 10 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 incontinent 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 and Medical Director at monthly Quality Assurance Performance Improvement (QAPI) for analysis and recommendation for continuation/discontinuation/revision of audits based on findings." 15. Interviews were completed by the survey team on 3/12/26 between 9:12 a.m. and 9:29 a.m. with residents 3, 35, and 65 and staff members LPN I, CNA T, medical records director OO, activity aide PP, housekeeper RR, and activity aide SS to ensure the provider followed through with their removal plan. 16. The survey team verified onsite, through interviews, and document review that the provider followed their IJ removal plan and the immediacy was removed. The scope and severity level of the noncompliance remained at a G. 17. On 3/12/26 at 9:54 a.m., administrator A was notified that the IJ was removed. 18. Review of resident 57's EMR revealed she was admitted to the facility on 5/17/17. Her 2/6/26 Brief Assessment for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She had diagnoses of Generalized Anxiety Disorder (GAD) (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), other manic episodes (a period of abnormally high energy, extreme happiness, or severe irritability), Agoraphobia (a fear of being in situations where escape might be difficult or help unavailable if a panic attack occurs), Major Depressive Disorder (MDD) (a persistent feeling of hopelessness, emptiness, or low mood). Review of resident 57's 2/22/26 care plan revealed that social services would visit with her to assess her psychosocial needs and would follow up as needed. She had a hearing deficit, and she was independent with toileting.	F0600		

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F0600 SS = SQC-J	Continued from page 11 Review of resident 57's medication record revealed she took Lexapro 20 milligrams (mg) (an antidepressant) daily and Seroquel 50 mg every night for MDD, and Depakote 250 mg twice daily for MDD and other manic episodes. 19. Review of resident 78's EMR revealed she was admitted to the facility on 11/6/25 and discharged to home on 12/8/25. Her 12/8/25 BIMS assessment score was 15, which indicated her cognition was intact. She had diagnoses of anxiety disorder and depression. Resident 78's 11/17/25 care plan did not indicate what assistance she required for personal hygiene care, ambulating (walking), or using the bathroom. Resident 78 had physician orders to take Mirtazapine 15 mg (a depression medication) daily. 20. Review of the provider's 5/14/25 Abuse and Neglect policy revealed that the facility would provide care services in an environment that was free from any type of abuse. And to follow federal guidelines to prevent abuse and investigate allegations of abuse. The abuse coordinator was the administrator, and she was "responsible for developing and implementing the abuse prevention training curriculum and conducting the investigation in situations of alleged abuse/neglect." Sexual abuse included "implied or actual contact between a caregiver and resident of sexual nature." "If an allegation of sexual abuse towards a resident is reported..., the facility will send resident to the emergency room to be evaluated if ordered by the resident's physician.... A report will be made to the local police department the same day the allegation is made." If abuse was suspected the facility would immediately protect the residents, notify appropriate authorities that an investigation would be conducted, "conduct a careful and deliberate investigation centering on	F0600		

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F0600 SS = SQC-J	Continued from page 12 facts, observations and statements from the alleged victim and witnesses", notify law enforcement if needed (example- Sexual abuse), and "report the investigation findings to all necessary state and/or local agencies and other identified persons as required by law." The steps indicated to prevent abuse were screening, training, prevention, identification, investigation, protection, and reporting/responding. The provider was to inform residents, residents' families, and staff how to report grievances or concerns and to whom they could report it to. The provider was to respond to the residents, families, or staff concerns that reported grievances or concerns. The administrator or designee was to investigate all abuse allegations of abuse immediately. The provider was to interview all people who might know information about the allegation to determine if abuse had occurred. The investigation was to be documented thoroughly. The provider was to protect residents from physical and psychosocial harm during the investigation, assess the resident for injury, notify the physician, and suspend the accused employee during the investigation. The provider was to report to the administrator immediately any allegations or suspicions of abuse. The allegation of abuse needed to be reported to the SD DOH within two hours of the allegation. A final investigation report was to be submitted to the state agency within five working days.	F0600		
F0609 SS = SQC-F	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	F0609	1.Resident 57's allegation of sexual abuse was reported to the South Dakota DOH, Beadle County Sheriff's Department, Dakota at Home, POA, and provider on 3/11/26. Resident 57 refused skin assessment on 3/11/26. Her previous skin assessment was completed by RN on 3/5/26 with no skin alterations or other injuries noted. Resident 57 was offered counseling services on March 12, 2026. CNA D was immediately suspended upon notification of allegation on 3/11/26. Resident 78's allegation of sexual abuse was reported to the DOH, Beadle County Sheriff's Department, Dakota at Home, and the facility Medical Director on 3/11/26. Resident 78 was discharged from the facility on 12/8/25. No immediate corrective action could be taken to ensure no injury occurred. COTA and SSD were immediately suspended on 3/11/26 for failure to report an allegation of sexual abuse. The above immediate corrective actions	April 14, 2026

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F0609 SS = SQC-F	Continued from page 13 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 the South Dakota Department of Health (SD DOH) complaint report review, interview, document review, record review, and policy review, the provider failed to implement policies and procedures to report to the SD DOH and law enforcement, allegations of sexual abuse for two of two sampled residents (57 and 78) who reported sexual abuse allegations to social service designee (SSD) (F) that they were touched in their private area by one of one certified nursing assistant (CNA) (D) and an unidentified staff member. The provider's failure to report those allegations to law enforcement for review and investigation may have put those residents at continued risk for further abuse and all residents at risk for potential abuse. Findings include: 1. Review of the complaint report submitted to the SD DOH on 2/6/26 revealed "that either a student or an aide had stuck their hands down her [resident 78's] pants to check if she was dry, without her permission. She stated her mind is good, and she had told the person that she didn't need to go to the toilet, and that she was dry. The aide or student proceeded to 'check' her without asking. She felt very embarrassed by this. She stated she spoke with facility management the next day, and they verified the person should not have done that. There was no further follow-up with the resident." She could not recall the name of the person who had done it, and the incident bothered her.	F0609	occurred upon discovery of the allegations during the DOH annual recertification/complaint survey. On 3/11/26, Nurse Managers completed interviews with all cognitive residents that have a BIMS score of 12 or greater, this included 32 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 completed interviews with all staff working evening and night shift on 3/11/26 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. Director of Nursing (DON) or designee completed 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 to report abuse concerns to. All interviews were completed as of March 17, 2026. 2.The Administrator and DON are responsible for completing the reporting of reportable events to the DOH and other entities. The facility's Regional Senior Nurse Consultant educated the Administrator and DON on the facility Abuse and Neglect Policy on 3/11/2026, to ensure an understanding of what constitutes a reportable event and on all aspects of timely reporting. The Administrator, DON, and IDT, in collaboration with the governing board and medical director reviewed the Abuse and Neglect policy and procedures to ensure residents are free from abuse. The policy and procedures do address care techniques for residents, including inappropriate staff-to-resident interactions that constitute abuse, timely reporting of all allegations of abuse to all applicable entities, timely notifications to all applicable parties, and processes to ensure complete and thorough investigation to mitigate the risks of future abuse. The Administrator, DON, or a Nurse Manager are educating all staff and contract staff on the Abuse and Neglect policy and procedures to ensure residents are free from abuse. The education includes inappropriate staff-to-resident interactions that constitute abuse, timely reporting of all allegations of abuse to all applicable entities, timely notifications to all applicable parties, and processes to ensure complete and thorough investigations to mitigate the risks of further abuse. DON or designee will educate all nursing staff and contract staff on appropriate approach and care techniques for checking a brief used for incontinence to maintain resident's psychosocial well-being and safety. Additionally, the DON or designee will complete a competency on abuse and neglect for all staff and contracted staff, as well as competency on appropriate approach and care technique when checking residents for incontinence for all nursing and contracted nursing staff. Education and competencies will occur no later than April 14, 2026, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. Education will be ongoing for all new staff.	

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F0609 SS = SQC-F	Continued from page 14 2. Interview on 3/10/26 at 12:21 p.m. with director of nursing (DON) B revealed that an internal investigation was completed after resident 57 complained to RN H that a staff member checked her incontinence brief to see if it was wet, which startled her since she was independent with using the bathroom. RN H reported that to DON B. DON B explained that CNA D did not mean it in a sexually inappropriate way so she did not report the incident to the SD DOH. The incident happened on 1/23/26 during the night shift rounds. She stated CNA D currently worked at the facility and she disciplined and educated CNA D after the incident. She acknowledged that touching a resident's incontinence brief was not an acceptable way to see if they were incontinent. She said the investigation report she completed indicated that resident 57's brief was not checked by touching her. If CNA D had touched the brief to see if it was wet, DON B would have reported it to the SD DOH, and CNA D would have been suspended until the investigation was completed, and possibly had his employment at the facility terminated. 3. Review of the provider's internal investigation form revealed that resident 57's abuse allegation was reported on 1/23/26 to RN H by resident 57 and stated "the night aide came in her room and pulled back her blanket and checked her brief which had startled her. [RN H] reported that [resident 57] did not feel that this was completed inappropriately towards her, but more of a lack of education." RN H reported this to DON B, and DON B had SSD F "conduct a social service visit to discuss the incident with [resident 57]." Review of SSD F interview documents that were attached to the internal investigation form revealed it stated, "I spoke with [resident 57] about what happened and checked on how she was feeling about the situation. [Resident 57] reported that staff entered her room during the overnight rounds while she was sleeping and she was not expecting someone to come in at that time. The CNA pulled down her blanket to check her brief which startled her. [Resident 57] and I talked about how the CNA was completing routine rounds and may not have known her usual nighttime routine. [Resident 57] stated she understood and said she does not believe the CNA meant anything inappropriate towards her. She also	F0609	3.The facility's Regional Senior Nurse Consultant or designee will audit five reportable events to ensure reports have been completed. These audits will be conducted weekly for four weeks and then monthly for three months. 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. DON or designee will interview 5 residents to ensure staff are checking them for incontinence appropriately to maintain their psychosocial well-being and safety. 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 incontinent 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 and Medical Director at monthly QAPI for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	

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F0609 SS = SQC-F	Continued from page 15 stated she is not upset with the CNA and felt he likely did not know her routine. I stayed with [resident 57] for a while and we continued to talk about the situation. During the visit she appeared calm and comfortable with discussing what happened. She did not express ongoing concerns. I asked if she would like me to notify family and she declined. Social Services will continue to monitor and remain available if she has any concerns. [Resident 57] reports that she feels safe at the facility." The internal investigation form indicated that the physician, police, ombudsman, and the state agency were not notified of the incident. On 1/26/26 SSD F interviewed resident 57 regarding the incident, and it stated "[Resident 57] reported that she has had no further issues. She remains to feel safe at the facility." On 1/27/26 SSD F interviewed resident 57 regarding the incident, and it indicated that resident 57 had no further issues, felt safe, and she would notify SSD if she had further issues. The outcome of the investigation summary section described the incident that had occurred. It stated that administrator A and DON B called resident 57's daughter to notify her of the incident, and her daughter said she would call them if resident 57 said anything about it. It stated that DON B interviewed CNA D on 1/23/26, and he reported that he said the resident's name before pulling the resident's blankets back. He thought she knew what he was doing, and he apologized that he startled her. DON B gave him a written warning. DON B told resident 57 that her care plan was changed, and the investigation summary indicated that resident 57 was happy with that. It stated, "In review of South Dakota's reporting guidelines this did not rise to the level of abuse/neglect due to [resident 57's] denial of inappropriate action towards her and [CNA D's] lack of touching her and therefore was not reported to the Department of Health." 4. Interview on 3/11/26 at 11:15 a.m. with SSD F revealed that CNA D touched the resident's incontinence	F0609		

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F0609 SS = SQC-F	Continued from page 16 brief to see if she was wet. SSD was unsure if resident 57's incontinence brief or private area was touched when CNA D checked her for incontinence. She verified that it was not an appropriate way to see if a resident was incontinent. 5. Interview on 3/11/26 at 11:40 a.m. with resident 57 revealed that the CNA touched her on the inside of her incontinence brief. She became tearful, and by the end of the interview she was not sure if she was touched on the inside or the outside of her incontinence brief, and she just wanted to forget about it. 6. Interview on 3/11/26 at 9:08 a.m. with RN H revealed that during a night shift, a CNA was confused about which residents needed to be checked for incontinence, and that the residents down the D wing were startled by this. The CNA still worked here, and she was not aware whether he continued to do that, and no residents had complained about that. 7. Interview on 3/11/26 at 12:50 p.m. with independent living specialist QQ regarding resident 78's complaint about a female staff member who put her hands down resident 78's pants to feel if she was wet, revealed resident 78 was no longer at the facility. Resident 78 was just there for rehab and at the time of the incident, she was independent with toileting. The incident made resident 78 feel uncomfortable and she reported to independent living specialist QQ that she had nightmares about it and recalled resident 78 saying got an "eerie gross feeling" about it. Independent living specialist QQ continued to stay in contact with her. She was not sure who resident 78 reported the incident to at the facility, but said resident 78 made a formal complaint, and she did not hear back from anyone about it. Independent living specialist QQ was unsure when the incident occurred. 8. Phone interview on 3/11/26 at 12:58 p.m. with resident 78 revealed she was unsure when the incident occurred, but she was able to recall that it happened during a night shift. The female staff member asked her if she needed to use the bathroom, and when resident 78 said no, the female staff member put her hand down resident 78's pants and said, "Nope, you're dry". Resident 78 reported that she had resided in the D wing, she wore her own underwear, and that a female	F0609		

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F0609 SS = SQC-F	Continued from page 17 staff member put her hand on the inside of her underwear when she checked her. She said she did not do anything about it that night, but the next day, she told COTA E about it. Resident 78 reported that COTA E brought her to SSD F's office for her to report the incident to SSD F. She said she reported the incident to the two women in that office, and said they had looked surprised. When she was telling them what happened, she thought it appeared that SSD F was looking at the staffing schedule to see who was working that night. Resident 78 was told that they had students from a vocational school there at the facility. Resident 78 stated that she had made a formal complaint with SSD F and the other lady that was in the office, and when she read her discharge paperwork from the facility, she did not see anything about the incident, so she made a complaint report with the SD DOH so it would not happen to other residents. She said no one from the facility followed up with her after she made the formal complaint. 9. Interview on 3/11/26 at 1:20 p.m. with COTA E revealed that resident 78 told her about the incident that occurred during the night shift, where a staff member put their hands in resident 78's pants to see if she was incontinent. COTA E reported that resident 78 was upset and that she was sleeping when that staff member came into her room. She said she took resident 78 directly to the social services office, and SSD F was there, but she was unsure if anyone else was in there. COTA E stated that was not the first time residents had reported this concern to her. She was not sure how many residents had, but thought five or less, in the last six months. Residents reported to her that the staff ripped off their blankets and would feel around to see if they were incontinent. It happened to the residents who were both continent and incontinent. She listed two other residents who were still in the facility, who she recalled having that happen to. 10. Interview on 3/11/26 at 1:45 p.m. with SSD F revealed that she did not recall COTA E bringing	F0609		

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F0609 SS = SQC-F	Continued from page 18 resident 78 to her office or that resident 78 made a formal complaint to her. She reported that the therapy department brought the residents to her office frequently about "this or that". She stated that their process for filing resident grievances was to listen to them, document the grievance, investigate them, and report them to the SD DOH if needed. SSD F said that she did not recall any other residents, besides resident 57, reporting that staff put their hands in their pants to check if they were incontinent and stated, "it's a pretty serious thing." She said that and incident like that would be reported to administrator A and DON B for them to investigate it. 11. Interview on 3/11/26 at 3:10 p.m. with DON B revealed she only received a complaint from resident 57 regarding staff putting their hands in her pants to check to see she was incontinent. If a resident had a complaint concerning abuse allegations, she would investigate it. If the investigation determined that the staff were inappropriate, then she would report it to the SD DOH. 12. Interview on 3/11/26 at 5:00 p.m. with administrator A and DON B revealed that they were not aware that resident 57 had was touched to check to see if she was incontinent. DON B had SSD F visit with resident 57 regarding the incident, and she thought resident 57 told SSD F that CNA D did not touch her. She explained how she updated the pocket care plan and that she talked with CNA D, provided him with education, and wrote him up. She stated that no other residents were interviewed. Administrator A stated that allegations of sexual abuse were to be reported to the SD DOH within two hours, reported to law enforcement, and Dakota at Home. She expected staff not to put their hands in the residents' incontinence briefs or touch the brief to check if the resident was incontinent. The incontinence brief had lines on it that turned color when it was wet, and the staff were to let the residents know what they were going to do and get their permission before they did anything. If a resident did not want to be checked, the staff were to report it to the charge nurse.	F0609		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA HURON	1345 MICHIGAN AVENUE SW , HURON, South Dakota, 57350

(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 = SQC-F	Continued from page 19 13. Review of resident 57's EMR revealed she was admitted to the facility on 5/17/17. Her 2/6/26 Brief Assessment for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She had diagnoses of Generalized Anxiety Disorder (GAD) (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), other manic episodes (a period of abnormally high energy, extreme happiness, or severe irritability), Agoraphobia (a fear of being in situations where escape might be difficult or help unavailable if a panic attack occurs), Major Depressive Disorder (MDD) (a persistent feeling of hopelessness, emptiness, or low mood). Review of resident 57's 2/22/26 care plan revealed that social services would visit with her to assess her psychosocial needs and would follow up as needed. She had a hearing deficit, and she was independent with toileting. Review of resident 57's medication record revealed she took Lexapro 20 milligrams (mg) (an antidepressant) daily and Seroquel 50 mg every night for MDD, and Depakote 250 mg twice daily for MDD and other manic episodes. Resident 78's 11/17/25 care plan did not indicate what assistance she required for personal hygiene care, ambulating (walking), or using the bathroom. Resident 78 had physician orders to take Mirtazapine 15 mg (a depression medication) daily. 14. Review of resident 78's medical record revealed she was admitted to the facility on 11/6/25 and discharged home on 12/8/25. Her 12/8/25 BIMS assessment score was 15, which indicated her cognition was intact. And she had diagnoses of Anxiety Disorder and Depression. Review of resident 78's 11/17/25 care plan revealed it did not indicate what assistance she required for hygiene care, ambulating, or using the bathroom. Review of resident 78's physician orders revealed she took Mirtazapine 15 mg (depression medication) daily.	F0609		

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F0609 SS = SQC-F	Continued from page 20 15. Review of the provider's 5/14/25 Abuse and Neglect policy revealed that the facility would provide care services in an environment that was free from any type of abuse. And to follow federal guidelines to prevent abuse and investigate allegations of abuse. The abuse coordinator was the administrator, and she was "responsible for developing and implementing the abuse prevention training curriculum and conducting the investigation in situations of alleged abuse/neglect." Sexual abuse included "implied or actual contact between a caregiver and resident of sexual nature." "If an allegation of sexual abuse towards a resident is reported..., the facility will send resident to the emergency room to be evaluated if ordered by the resident's physician.... A report will be made to the local police department the same day the allegation is made." If abuse was suspected the facility would immediately protect the residents, notify appropriate authorities that an investigation would be conducted, "conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses", notify law enforcement if needed (example- Sexual abuse), and "report the investigation findings to all necessary state and/or local agencies and other identified persons as required by law." The steps indicated to prevent abuse were screening, training, prevention, identification, investigation, protection, and reporting/responding. The provider was to inform residents, residents' families, and staff how to report grievances or concerns and to whom they could report it to. The provider was to respond to the residents, families, or staff concerns that reported grievances or concerns. The administrator or designee was to investigate all abuse allegations of abuse immediately. The provider was to interview all people who might know information about the allegation to determine if abuse had occurred. The investigation was to be documented	F0609		

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F0609 SS = SQC-F	Continued from page 21 thoroughly. The provider was to protect residents from physical and psychosocial harm during the investigation, assess the resident for injury, notify the physician, and suspend the accused employee during the investigation. The provider was to report to the administrator immediately any allegations or suspicions of abuse. The allegation of abuse needed to be reported to the SD DOH within two hours of the allegation. A final investigation report was to be submitted to the state agency within five working days.	F0609		
F0610 SS = G	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on the South Dakota Department of Health (SD DOH) complaint report review, interview, document review, record review, and policy review, the provider failed to ensure two of two sampled residents' with expressed feelings of emotional distress (57 and 78) allegations of sexual abuse reported to social services designee (F) regarding having been touched in their private areas without the residents' consent by one of one certified nursing assistant (CNA) (D) and an unidentified staff member were thoroughly investigated	F0610	1.Resident 57's allegation of sexual abuse was reported to the South Dakota DOH, Beadle County Sheriff's Department, Dakota at Home, her POA, and provider on 3/11/26. Resident 57 refused skin assessment on 3/11/26. Her previous skin assessment was completed by RN on 3/5/26 with no skin alterations or other injuries noted. Resident 57 was offered counseling services on March 12, 2026. CNA D was immediately suspended upon notification of allegation on 3/11/26. Resident 78's allegation of sexual abuse was reported to the DOH, Beadle County Sheriff's Department, Dakota at Home, and the facility Medical Director on 3/11/26. Resident 78 was discharged from the facility on 12/8/25. No immediate corrective action could be taken to ensure no injury occurred. COTA and SSD were immediately suspended on 3/11/26 for failure to report an allegation of sexual abuse. The above immediate corrective actions occurred upon discovery of the allegations during the DOH annual recertification/complaint survey. On 3/11/26, Nurse Managers completed interviews with all cognitive residents that have a BIMS score of 12 or greater, this included 32 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 completed interviews with all staff working evening and night shift on 3/11/26 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. DON or designee completed 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 to report abuse concerns to. All interviews were completed as of March 17, 2026. Continued on next page.....	April 14, 2026

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F0610 SS = G	Continued from page 22 to prevent further emotional distress, further staff-to-resident sexual abuse or to mitigate the risk of sexual abuse. Findings include: 1. Review of the provider's complaint report submitted to the SD DOH on 2/6/26 revealed "that either a student or an aide had stuck their hands down her [resident 78's] pants to check if she was dry, without her permission. She stated her mind is good, and she had told the person that she didn't need to go to the toilet, and that she was dry. The aide or student proceeded to 'check' her without asking. She felt very embarrassed by this. She stated she spoke with facility management the next day, and they verified the person should not have done that. There was no further follow-up with the resident." She could not recall the name of the person who had done it, and the incident bothered her. 2. Interview on 3/10/26 at 12:21 p.m. with director of nursing (DON) B revealed that an internal investigation was completed after resident 57 complained to RN H that a staff member checked her incontinence brief to see if it was wet, which startled her since she was independent with using the bathroom. RN H reported that to DON B. DON B explained that CNA D did not mean it in a sexually inappropriate way so she did not report the incident to the SD DOH. The incident happened on 1/23/26 during the night shift rounds. She stated CNA D currently worked at the facility and she disciplined and educated CNA D after the incident. She acknowledged that touching a resident's incontinence brief was not an acceptable way to see if they were incontinent. She said the investigation report she completed indicated that resident 57's brief was not checked by touching her. If CNA D had touched the brief to see if it was wet, DON B would have reported it to the SD DOH, and CNA D would have been suspended until the investigation was completed, and possibly had his employment at the facility terminated. No audits were completed after the incident occurred to ensure it would not occur again. DON B told resident 57's daughter about the incident and asked her daughter to notify them if resident 57 brought it up. The investigation documentation stated SSD F had followed up with resident 57 a few days after the incident.	F0610	2. The Administrator and DON are responsible for investigating all reportable events submitted to the DOH and other entities. The facility's Regional Senior Nurse Consultant educated the Administrator and DON on the facility Abuse and Neglect Policy on 3/11/2026, to ensure an understanding of what constitutes an investigation and to ensure a timely investigation is conducted on all reportable events.The Administrator, DON, and IDT, in collaboration with the governing board and medical director reviewed the Abuse and Neglect policy and procedures to ensure residents are free from abuse. The policy and procedures do address care techniques for residents, including inappropriate staff-to-resident interactions that constitute abuse, timely reporting of all allegations of abuse to all applicable entities, timely notifications to all applicable parties, and processes to ensure complete and thorough investigation to mitigate the risks of future abuse. The Administrator, DON, or a Nurse Manager are educating all staff and contract staff on the Abuse and Neglect policy and procedures to ensure residents are free from abuse. The education includes inappropriate staff-to-resident interactions that constitute abuse, timely reporting of all allegations of abuse to all applicable entities, timely notifications to all applicable parties, and processes to ensure complete and thorough investigations to mitigate the risks of further abuse. DON or designee will educate all nursing staff and contract staff on appropriate approach and care techniques for checking a brief used for incontinence to maintain resident's psychosocial well-being and safety. Additionally, the DON or designee will complete a competency on abuse and neglect for all staff and contracted staff, as well as competency on appropriate approach and care technique when checking residents for incontinence for all nursing and contracted nursing staff. Education and competencies will occur no later than April 14, 2026, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. Education will be ongoing for all new staff. 3. The facility's Regional Senior Nurse Consultant or designee will audit five reportable events to ensure thorough and timely investigation have been completed on all reportable events.. These audits will be conducted weekly for four weeks and then monthly for three months. 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. DON or designee will interview 5 residents to ensure staff are checking them for incontinence appropriately to maintain their psychosocial well-being and safety. 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 incontinent 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 and Medical Director at monthly QAPI for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	

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F0610 SS = G	Continued from page 23 3. Review of the provider's internal investigation form revealed that resident 57's abuse allegation was reported on 1/23/26 to RN H by resident 57 and stated "the night aide came in her room and pulled back her blanket and checked her brief which had startled her. [RN H] reported that [resident 57] did not feel that this was completed inappropriately towards her, but more of a lack of education." RN H reported this to DON B, and DON B had SSD F "conduct a social service visit to discuss the incident with [resident 57]." Review of SSD F interview documents that were attached to the internal investigation form revealed it stated, "I spoke with [resident 57] about what happened and checked on how she was feeling about the situation. [Resident 57] reported that staff entered her room during the overnight rounds while she was sleeping and she was not expecting someone to come in at that time. The CNA pulled down her blanket to check her brief which startled her. [Resident 57] and I talked about how the CNA was completing routine rounds and may not have known her usual nighttime routine. [Resident 57] stated she understood and said she does not believe the CNA meant anything inappropriate towards her. She also stated she is not upset with the CNA and felt he likely did not know her routine. I stayed with [resident 57] for a while and we continued to talk about the situation. During the visit she appeared calm and comfortable with discussing what happened. She did not express ongoing concerns. I asked if she would like me to notify family and she declined. Social Services will continue to monitor and remain available if she has any concerns. [Resident 57] reports that she feels safe at the facility." The internal investigation form indicated that the physician, police, ombudsman, and the state agency were not notified of the incident. On 1/26/26 SSD F interviewed resident 57 regarding the incident, and it stated "[Resident 57] reported that she has had no further issues. She remains to feel safe at the facility." On 1/27/26 SSD F interviewed resident 57 regarding the	F0610		

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F0610 SS = G	Continued from page 24 incident, and it indicated that resident 57 had no further issues, felt safe, and she would notify SSD if she had further issues. The outcome of the investigation summary section described the incident that had occurred. It stated that administrator A and DON B called resident 57's daughter to notify her of the incident, and her daughter said she would call them if resident 57 said anything about it. It stated that DON B interviewed CNA D on 1/23/26, and he reported that he said the resident's name before pulling the resident's blankets back. He thought she knew what he was doing, and he apologized that he startled her. DON B gave him a written warning. DON B told resident 57 that her care plan was changed, and the investigation summary indicated that resident 57 was happy with that. It stated, "In review of South Dakota's reporting guidelines this did not rise to the level of abuse/neglect due to [resident 57's] denial of inappropriate action towards her and [CNA D's] lack of touching her and therefore was not reported to the Department of Health." 4. Interview on 3/11/26 at 11:15 a.m. with SSD F revealed that CNA D touched the resident's incontinence brief to see if she was wet. SSD was unsure if resident 57's incontinence brief or private area was touched when CNA D checked her for incontinence. She verified that it was not an appropriate way to see if a resident was incontinent. 5. Interview on 3/11/26 at 11:40 a.m. with resident 57 revealed that the CNA touched her on the inside of her incontinence brief. She became tearful, and by the end of the interview she was not sure if she was touched on the inside or the outside of her incontinence brief, and she just wanted to forget about it. 6. Interview on 3/11/26 at 9:08 a.m. with RN H revealed that one night, a CNA was confused about which residents needed to be checked for incontinence, and that the residents down the D wing were alerted by this. He still worked here, and she was not aware whether he continued to do that. She had not had a resident come to her to complain about that.	F0610		

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F0610 SS = G	Continued from page 25 7. Interview on 3/11/26 at 12:50 p.m. with independent living specialist QQ regarding resident 78's complaint about a female staff member who put her hands down resident 78's pants to feel if she was wet, revealed resident 78 was no longer at the facility. Resident 78 was just there for rehab and at the time of the incident, she was independent with toileting. The incident made resident 78 feel uncomfortable and she reported to independent living specialist QQ that she had nightmares about it and recalled resident 78 saying got an "eerie gross feeling" about it. Independent living specialist QQ continued to stay in contact with her. She was not sure who resident 78 reported the incident to at the facility, but said resident 78 made a formal complaint, and she did not hear back from anyone about it. Independent living specialist QQ was unsure when the incident occurred. 8. Phone interview on 3/11/26 at 12:58 p.m. with resident 78 revealed she was unsure when the incident occurred, but she was able to recall that it happened during a night shift. The female staff member asked her if she needed to use the bathroom, and when resident 78 said no, the female staff member put her hand down resident 78's pants and said, "Nope, you're dry". Resident 78 reported that she had resided in the D wing, she wore her own underwear, and that a female staff member put her hand on the inside of her underwear when she checked her. She said she did not do anything about it that night, but the next day, she told COTA E about it. Resident 78 reported that COTA E brought her to SSD F's office for her to report the incident to SSD F. She said she reported the incident to the two women in that office, and said they had looked surprised. When she was telling them what happened, she thought it appeared that SSD F was looking at the staffing schedule to see who was working that night. Resident 78 was told that they had students from a vocational school there at the facility. Resident 78 stated that she had made a formal complaint with SSD F and the other lady that was in the office, and when she read her discharge paperwork from the facility, she did not see anything about the incident, so she made a complaint report with the SD DOH so it would not happen to other residents. She said no one from the facility followed up with her after she made	F0610		

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F0610 SS = G	Continued from page 26 the formal complaint. 9. Interview on 3/11/26 at 1:20 p.m. with COTA E revealed that resident 78 told her about the incident that occurred during the night shift, where a staff member put their hands in resident 78's pants to see if she was incontinent. COTA E reported that resident 78 was upset and that she was sleeping when that staff member came into her room. She said she took resident 78 directly to the social services office, and SSD F was there, but she was unsure if anyone else was in there. COTA E stated that was not the first time residents had reported this concern to her. She was not sure how many residents had, but thought five or less, in the last six months. Residents reported to her that the staff ripped off their blankets and would feel around to see if they were incontinent. It happened to the residents who were both continent and incontinent. She listed two other residents who were still in the facility, who she recalled having that happen to. 10. Interview on 3/11/26 at 1:45 p.m. with SSD F revealed that she did not recall COTA E bringing resident 78 to her office or that resident 78 made a formal complaint to her. She reported that the therapy department brought the residents to her office frequently about "this or that". She stated that their process for filing resident grievances was to listen to them, document the grievance, investigate them, and report them to the SD DOH if needed. SSD F said that she did not recall any other residents, besides resident 57, reporting that staff put their hands in their pants to check if they were incontinent and stated, "it's a pretty serious thing." She said that and incident like that would be reported to administrator A and DON B for them to investigate it. Regarding resident 57, she stated she wrote her follow-up notes in a notebook, which she no longer had, and did not document about it in the electronic medical record (EMR). She said she did not talk to other staff or residents to see if a similar incident occurred with them. She said she visited with resident 57, but no other counseling was offered to her. When she talked to	F0610		

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F0610 SS = G	Continued from page 27 resident 57 about the incident, she told SSD F that she was embarrassed about it. 11. Interview on 3/11/26 at 2:27 p.m. with SSD G revealed that she did not recall any complaints regarding staff putting their hands down residents' pants to check to see if they were incontinent, and she did not recall COTA E bringing resident 78 to her office. If she were to receive a resident grievance, she was to document it on a form and turn it in to administrator A. 12. Interview on 3/11/26 at 3:10 p.m. with DON B revealed she only received a complaint from resident 57 regarding staff putting their hands in her pants to check to see she was incontinent. If a resident had a complaint concerning abuse allegations, she would investigate it. If the investigation determined that the staff were inappropriate, then she would report it to the SD DOH. Regarding the incident that involved resident 57, she interviewed RN H and the other night nurses about CNA D, but she did not document those interviews. She did not interview other residents to see if there was a similar incident that had happened to them. Mental health services were not offered to resident 57. 13. Interview on 3/11/26 at 5:00 p.m. with administrator A and DON B revealed that they were not aware that resident 57 had was touched to check to see if she was incontinent. DON B had SSD F visit with resident 57 regarding the incident, and she thought resident 57 told SSD F that CNA D did not touch her. She explained how she updated the pocket care plan and that she talked with CNA D, provided him with education, and wrote him up. She stated that no other residents were interviewed. She expected staff not to put their hands in the residents' incontinence briefs or touch the brief to check if the resident was incontinent. The incontinence brief had lines on it that turned color when it was wet, and the staff were to let the residents know what they were going to do and get their permission before they did anything. If a resident did not want to be checked, the staff were to report it to the charge nurse.	F0610		

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F0610 SS = G	Continued from page 28 14. Review of resident 57's EMR revealed she was admitted to the facility on 5/17/17. Her 2/6/26 Brief Assessment for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She had diagnoses of Generalized Anxiety Disorder (GAD) (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), other manic episodes (a period of abnormally high energy, extreme happiness, or severe irritability), Agoraphobia (a fear of being in situations where escape might be difficult or help unavailable if a panic attack occurs), Major Depressive Disorder (MDD) (a persistent feeling of hopelessness, emptiness, or low mood). Review of resident 57's 2/22/26 care plan revealed that social services would visit with her to assess her psychosocial needs and would follow up as needed. She had a hearing deficit, and she was independent with toileting. Review of resident 57's medication record revealed she took Lexapro 20 milligrams (mg) (an antidepressant) daily and Seroquel 50 mg every night for MDD, and Depakote 250 mg twice daily for MDD and other manic episodes. Resident 78's 11/17/25 care plan did not indicate what assistance she required for personal hygiene care, ambulating (walking), or using the bathroom. Resident 78 had physician orders to take Mirtazapine 15 mg (a depression medication) daily. 15. Review of resident 78's medical record revealed she was admitted to the facility on 11/6/25 and discharged home on 12/8/25. Her 12/8/25 BIMS assessment score was 15, which indicated her cognition was intact. And she had diagnoses of Anxiety Disorder and Depression. Review of resident 78's 11/17/25 care plan revealed it did not indicate what assistance she required for hygiene care, ambulating, or using the bathroom. Review of resident 78's physician orders revealed she took Mirtazapine 15 mg (depression medication) daily.	F0610		

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F0610 SS = G	Continued from page 29 16. Review of the provider's 5/14/25 Abuse and Neglect policy revealed that the facility would provide care services in an environment that was free from any type of abuse. And to follow federal guidelines to prevent abuse and investigate allegations of abuse. The abuse coordinator was the administrator, and she was "responsible for developing and implementing the abuse prevention training curriculum and conducting the investigation in situations of alleged abuse/neglect." Sexual abuse included "implied or actual contact between a caregiver and resident of sexual nature." "If an allegation of sexual abuse towards a resident is reported..., the facility will send resident to the emergency room to be evaluated if ordered by the resident's physician.... A report will be made to the local police department the same day the allegation is made." If abuse was suspected the facility would immediately protect the residents, notify appropriate authorities that an investigation would be conducted, "conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses", notify law enforcement if needed (example- Sexual abuse), and "report the investigation findings to all necessary state and/or local agencies and other identified persons as required by law." The steps indicated to prevent abuse were screening, training, prevention, identification, investigation, protection, and reporting/responding. The provider was to inform residents, residents' families, and staff how to report grievances or concerns and to whom they could report it to. The provider was to respond to the residents, families, or staff concerns that reported grievances or concerns. The administrator or designee was to investigate all abuse allegations of abuse immediately. The provider was to interview all people who might know information about the allegation to determine if abuse had occurred. The investigation was to be documented	F0610		

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F0610 SS = G	Continued from page 30 thoroughly. The provider was to protect residents from physical and psychosocial harm during the investigation, assess the resident for injury, notify the physician, and suspend the accused employee during the investigation.	F0610		
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 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 and Centers for Medicare and Medicaid Services (CMS) Long-Term Care	F0641	1.Registered Nurse (RN)/Minimum Data Set (MDS) Coordinator C modified resident 7's 1/28/26 significant change MDS assessment on March 11, 2026, upon discovery during the annual recertification survey, to reflect that resident 7 received an antidepressant medication. RN/MDS Coordinator C modified resident 57's 10/27/25 comprehensive MDS assessment on March 11, 2026, upon discovery during the annual recertification survey, to reflect that she did have a Pre-Admission Screening and Resident Review (PASRR) level II. RN/MDS Coordinator C modified resident 10's 9/22/25 comprehensive assessment on March 9, 2026, upon discovery during the annual recertification survey, to reflect that he did have a PASARR level II. RN/MDS Coordinator C modified resident 10's 9/26/24 comprehensive assessment on April 2, 2026, to reflect that he did have a PASRR level II. No immediate corrective action could be taken for resident 10's 5/12/23 comprehensive assessment due to the limit of 2 years to complete modifications to completed MDS assessments. All residents are at risk for inaccurate coding of antidepressant use and PASRR level II. DON or designee will audit all residents' most recent comprehensive MDS assessment to ensure antidepressant medication use is marked if indicated per review of physician orders and PASRR level II is marked if indicated per review of each resident's PASRR level. 2. Vice President of Clinical Reimbursement and Assessment will educate RN/MDS Coordinator C and RN Z on sections of the Resident Assessment Instrument (RAI) 3.0 User's Manual to ensure the MDS is accurately coded for all areas to reflect the resident's status including the areas of medications and PASRRs. Education will be completed no later than April 14, 2026. 3. DON or designee will audit 5 residents' newly completed MDS assessments to ensure all MDS's are coded accurately to reflect the resident's status and will include if a resident is receiving an antidepressant that section N (medications) is marked appropriately to reflect that resident is receiving an antidepressant. Additionally, DON or designee will audit all newly completed comprehensive MDS assessments to ensure question A1500 is marked yes for residents with a PASRR level II. Audits will be completed weekly for 4 weeks and then monthly for 2 months. Results of audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	April 14, 2026

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F0641 SS = D	Continued from page 31 Facility Resident Assessment Instrument (RAI) 3.0 User's Manual review, the provider failed to ensure three of five sampled residents' (7, 10, and 57) 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 of medications and Pre-Admission Screening and Resident Review (PASRR). Findings include: 1. Review of resident 7's electronic medical record (EMR) revealed: *She was admitted to the facility on 8/15/24. *She had an 8/22/24 physician's order for Escitalopram (an antidepressant medication) 20 milligrams (mg) once daily for depression. *Her 1/28/26 significant change MDS assessment, section N (medications) indicated she was taking antipsychotic, antianxiety, opioid, and anticonvulsant medications, but it did not identify her as taking an antidepressant medication. 2. Interview and record review on 3/11/26 at 10:36 a.m. with registered nurse (RN)/MDS coordinator C revealed: *She acknowledged that resident 7 had a physician's order dated 8/22/24 for Escitalopram 20 mg tablet once daily. *She reviewed resident 7's 1/28/26 significant change MDS assessment, section N for and agreed it was not marked correctly since she was taking an antidepressant medication. *She stated RN Z completed section N of residents' significant change MDS assessment. *When completing the MDS assessments they pull the residents' medication administration records (MAR) and treatment administration records (TAR). *She used the CMS Long-Term Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 to complete the residents' MDS assessments. 3. Review of resident 57's EMR revealed she had an	F0641		

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F0641 SS = D	Continued from page 32 approved PASRR Level II (an in-depth evaluation required by federal law for anyone applying to a Medicaid-certified nursing home who is suspected of having a serious mental illness [SMI] or an intellectual/developmental disability [I/DD]) on 4/22/25. Her 10/27/25 comprehensive MDS assessment, indicated she did not have a PASRR level II. Resident 57's care plan indicated that her PASRR level II was added on 2/22/26. Resident 57 had diagnoses of generalized anxiety disorder (GAD) (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), other manic episodes (a period of abnormally high energy, intense euphoria, or extreme irritability, where a person feels "on top of the world" or reckless), Agoraphobia (fear of certain places or situations), and major depressive disorder (MDD) (persistent feeling of sadness, emptiness, or loss of interest in activities). Resident 57's physician's orders included social services as needed and psychiatric consult started on 10/11/22, Lexapro 20 mg (a medication for depression) daily started on 5/26/23, monitor for behaviors started on 4/25/25, Depakote 250 mg twice daily started on 3/12/25, and Seroquel 50 mg daily started on 6/17/25. 4. Review of resident 10's EMR revealed he was admitted to the facility on 5/12/22. His diagnoses included bipolar disorder (a mental condition causing extreme shifts in mood, energy, and activity levels), anxiety disorder, and adjustment disorder with depressed mood. He had a level I (1) PASRR completed on 12/27/23 and again on 10/16/24 due to a potential change in his mental status. The 12/27/23 and 10/16/24 Level I PASRRs stated, "Your Level I screen was submitted for a potential status change. It shows that you have evidence of serious mental illness or an intellectual/developmental disability (IDD). However, your condition does not require further PASRR evaluation at this time because your serious mental illness or IDD treatment needs have not significantly changed since your previous PASRR Level II evaluation." -"The facility should mark yes for question A1500 on the MDS 'Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition?'"	F0641		

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F0641 SS = D	Continued from page 33 Item A1500 in section A of his 9/22/25 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?" -Item A1500 in section A was coded "No" on resident 10's 9/26/24 and 5/12/23 comprehensive MDS assessments, and "yes" on his 9/15/23 comprehensive MDS assessments. 5. Interview on 3/9/26 at 2:34 p.m. with RN/MDS coordinator C revealed she confirmed resident 10 had a severe mental illness, the 12/27/23 Notice of PASRR Level I Screening Outcome indicated the facility should mark "yes" for question A1500 on the MDS, and that section A1500 of resident 10's 5/12/23, 9/26/24, and 9/22/25 MDS was marked "no." She stated she had miscoded that section of the MDS assessment for resident 10. 6. Interview on 3/11/26 at 11:36 a.m. with director of nursing (DON) B revealed social services designee (SSD) F completed the PASRR screenings, and RN/MDS coordinator C coded that information on the MDS assessment. She was unaware that resident 10's MDS assessment was not coded correctly. 7. Interview on 3/11/25 at 12:48 p.m. with SSD F revealed she completed PASSR screenings, and RN/MDS coordinator C completed the MDS assessment. 8. Interview on 3/11/25 at 4:23 p.m. with administrator A revealed she expected SSD F to complete the PASSR screening and to communicate with RN/MDS coordinator C for accurate coding on the MDS assessments. 9. The provider's 5/15/26 Preadmission Screening and Resident Review PASRR policy revealed "the Preadmission Screening and Resident Review (PASRR) is a federal requirement to ensure the Nursing Facility (NF) residents with Serious Mental Illness (SMI) or Intellectual and Developmental Disability (ID/DD) are identified and evaluated, placed in the most appropriate and least restrictive setting available, transitioned to an appropriate community setting when they no longer meet criteria for NF placement, and to provide with the MI/ID/DD services they need, including specialized services."	F0641		

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F0641 SS = D	Continued from page 34 10. Review of the CMS Long-Term Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 revealed: 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 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) for one of one sampled resident (32) with a new psychosis	F0644	1.A PASRR review was submitted for resident 32 with a new diagnosis of psychosis on March 9, 2026, upon discovery during the annual recertification survey. Results of the determination were received on March 10, 2026, and remain unchanged with no evidence of serious mental illness or intellectual/developmental disability indicating a level I PASRR. All residents with a level I PASRR are at risk for not having a completed level II PASRR review upon a significant change in status assessment. All residents with a level I PASRR will be audited to determine if a level II PASRR review is required due to a significant change of condition no later than April 14, 2026. 2.Licensed Social Worker Consultant will educate Social Service Designee (SSD) F and SSD G on the Preadmissions Screening and Resident Review (PASRR) policy to ensure residents with a level I PASRR be reviewed for a level II PASRR due to a significant change of condition. Education will be completed no later than April 14, 2026. 3.The DON or designee will audit 5 residents with a level I PASRR to ensure that a level II PASRR review has been completed if a significant change in status assessment has occurred. Audits will be completed weekly for 4 weeks and then monthly for 2 months. Results of audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	April 14, 2026

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F0644 SS = D	Continued from page 35 diagnosis. Findings Include: 1. Review of resident 32's electronic medical record (EMR) revealed he was admitted to the facility on 1/21/26 and had a diagnosis of unspecified psychosis that was documented on 1/23/26. 2. Resident 32's 1/19/26 PASRR level 1 screening form did not a indicate a confirmed or suspected mental illness diagnosis. 3. Interview on 3/11/26 at 12:45 p.m. with social services designee (SSD) F revealed that she did not complete a PASRR level 2 on resident 32. The nursing staff was to let her know if there was an update in the residents' diagnoses within the facility. SSD F was not aware if the nursing staff informed her of resident 32's psychosis diagnosis. 4. Review of the provider's May 2025 Preadmission Screening and Resident Review (PASRR) policy revealed "individuals who have or are suspected to have MD [mental diagnosis], ID [intellectual disability] or a related condition (as indicated by a positive level 1 screen) may not be admitted to a Medicaid-certified nursing facility unless approved based on level II PASARR evaluation and determination."	F0644		
F0655 SS = D	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.	F0655	1.No immediate corrective action could be taken for resident 42's baseline care plan not including how she transferred within 48 hours of admission. No immediate corrective action could be taken for resident 56's baseline care plan not including how she transferred or what her diet was within 48 hours of admission. All residents are at risk for their baseline care plan to not be completed to include all the regulatory components withing the required time frame, including how they are transferred or what their diet was within 48 hours of admission. 2.DON or designee will educate the IDT, to include Registered Nurse (RN) nurse supervisor O on the Care Plan policy to ensure resident-centered care planning is initiated upon admission to ensure their baseline care plan reflects all of the regulatory components required within the required timeframe including how the resident is transferred and what their current diet is within 48 hours of admission. Education will occur no later than April 14, 2026. .....continued on next page	April 14, 2026

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F0655 SS = D	Continued from page 36 (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (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) was complete within 48 hours of the resident's admission to the facility for two of five newly admitted sampled residents (42 and 56). Findings include: 1. Review of resident 42's baseline care plan revealed	F0655	3.DON or designee will audit all new admissions to ensure their baseline care plan includes all regulatory components including how the resident transfers and what their diet order is within the required timeframe. Audits will be completed weekly for 4 weeks and then monthly for 2 months. Results of audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F0655 SS = D	Continued from page 37 she was admitted to the facility on 2/2/26. She required the assistance of one staff member and a gait belt [a waist strap gripped as support for safe mobility and transfers) for ambulation (walking) and was to use a wheelchair for long distances, which was indicated on her baseline care plan on 3/8/26. 2. Review of resident 56's baseline care plan revealed she was admitted to the facility on 2/24/25. She required the assistance of one staff member, which was added to her baseline care plan on 3/4/25. Her diet order was for a liberal renal diet (a diet that is kidney-friendly to reduce the workload on damaged kidneys), which was added to her baseline care plan on 8/22/25. 3. Interview on 3/11/26 at 8:51 a.m. with registered nurse (RN) nurse supervisor O revealed that she and the charge nurse on duty completed the baseline care plans when a resident was admitted to the facility. She verified that resident 42's baseline care plan did not include how the resident transferred within 48 hours of admission, and that it should have. She verified that resident 56's baseline care plan did not include how the resident transferred or what her diet was within 48 hours of admission, and that it should have. 4. Interview on 3/12/26 at 10:25 a.m. with director of nursing (DON) B revealed that resident baseline care plans were expected to have information on how the resident transferred within 48 hours of their admission to the facility. She did not think that the resident's diet needed to be on the baseline care plan and thought it was acceptable for it to state, "diet as ordered". If the staff needed to know the resident's diet, then they needed to look at the physician's order. 5. Review of the provider's 5/14/25 Care Plans policy revealed that "resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence." "A Baseline Care Plan is started by nursing staff on the first day of admission to provide guidance to direct care givers as soon as possible after admission and [is] completed no later than 48 hours after admission. Nursing, Dietary, Activities and Social Services staff complete formal assessments, interviews	F0655		

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F0655 SS = D	Continued from page 38 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 deadline). The areas that must be addressed in the baseline care plan 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...." "The DON will be responsible for holding the team accountable to initiating and completing the Admission care plan within 48 hours...."	F0655		
F0657 SS = D	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:	F0657	1.Resident 84's care plan was updated to reflect his need for Enhanced Barrier Precautions (EBP) on March 9, 2026, related to indwelling drain d/t abscess upon discovery during annual recertification survey. Resident 10's care plan will be updated to reflect his level II PASRR recommendations no later than April 14, 2026. Resident 32's care plan was updated to incorporate his hospice care plan into the resident's facility care plan used by staff on March 11, 2026, upon discovery during the annual recertification survey. A full house care plan audit will be conducted to ensure residents requiring EBP is care planned, residents' level II PASRR recommendations are care planned, and residents receiving hospice services have a hospice care plan that is incorporated with the facility's care plan used by staff. 2.The DON or designee will educate the IDT, to include RN/MDS Coordinator, SSD F, RN Nurse Supervisors O and X, on the Care Plan policy to ensure residents' care plans reflect the current care needs of the residents which include EBP, PASRR, and hospice services and that the hospice care plan is incorporated into the facility's care plan to ensure residents' individualized care needs are met. 3. The DON or designee will audit 5 residents' care plans to ensure their care plans reflect the current care needs of the residents to include EBP, PASRR, and hospice services, and residents receiving hospice services have a hospice care plan that is incorporated into the facility care plan used by staff. Audits will be completed weekly for 4 weeks and then monthly for 2 months. Results of audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	April 14, 2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

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F0657 SS = D	Continued from page 39 Based on observation, interview, record review, and policy review, the provider failed to ensure the residents' care plans (personalized plan that addresses a resident's care needs, goals, and interventions) were reviewed and revised to reflect the current care needs for three of twenty sampled residents (10, 32, and 84). Findings include: 1. Interview and observation on 3/8/26 at 3:24 p.m. of resident 84 in his room revealed he had a right abdominal drainage bag under his shirt with red drainage in the bag. He denied staff using gloves or gowns when they emptied the drainage bag. There was no signage or supplies for enhanced barrier precautions (EBP) (glove and gown use when providing contact care) in his room. 2. Observation on 3/9/26 at 8:22 a.m. of resident 84's room and outside of his room, revealed there was no signage for the use of EBP. 3. Observation on 3/9/26 at 3:01 p.m. of resident 84's room revealed, there were EBP supplies for the staff to use and a sign hanging on his door indicating he was on EBP. 4. Review of resident 84's electronic medical record (EMR) revealed: *His was admitted to the facility on 2/26/26. *His 3/3/26 Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated his cognition was intact. *His primary diagnosis was a peritoneal abscess (localized collection of pus/infection within the abdominal cavity). *He had a 2/27/26 physician's order to cleanse the right abdomen tube site daily with saline and cover it with gauze and tape. *His 2/26/26 nursing admission UDA (user-defined assessment) indicated: -Section V was marked as having a right upper quadrant (RUQ) 16 French (a medium-to-large tube) abdominal drain.	F0657		

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F0657 SS = D	Continued from page 40 -Section X was marked "no" for needing any type of isolation to prevent the spread of infection. *His care plan indicated he had a potential for infection related to: I.V. Line, other; specify) initiated on 2/26/26 with a goal of not developing signs and symptoms of infection initiated on 3/6/26. The interventions were to access for signs and symptoms of infection and to give medications and treatments as ordered, which were initiated on 2/26/26. *His care plan indicated he had a potential for skin impairment, with a goal of not developing signs and symptoms of infection on the wound site and to apply wound treatment as ordered by the physician, which was initiated on 2/26/26. 5. Interview and record review on 3/10/26 at 10:44 a.m. with certified nursing assistant (CNA) S revealed: *She had worked at the facility for ten years. *Resident 84 had the abdominal drainage bag when he was admitted to the facility. *She agreed that resident 84 had no EBP in his room until 3/9/26 when it was placed. *She stated there was EBP available in the resident room next door. *She used the Kardex (a report of the resident's care needs and interventions) to know how to care for the residents. *She acknowledged that resident 84's information on the current 3/6/26 Kardex did not indicate he was required to be on EBP, but it did indicate that he had a drain to the right side of his abdomen. 6. Interview on 3/10/26 at 10:50 a.m. with licensed practical nurse (LPN) AA revealed: *CNA's refer to the Kardex for the residents' information. *Resident 84's current Kardex dated 3/6/26 indicated he requires EBP to be used by the staff when they were providing him with direct care.	F0657		

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F0657 SS = D	Continued from page 41 7. Interview on 3/10/26 at 11:39 a.m. with LPN L revealed: *It was her responsibility to place all EBP supplies in the resident rooms. *She knew resident 84 was admitted to the facility on 2/26/26. *She was not aware resident 84 needed the EBP until 3/9/26 around 9:00 a.m., which was when she placed the EBP sign and supplies on his door. *She would read through a resident's physician's orders to see if the resident needed EBP placed upon admission or readmission. *She would tell registered nurse (RN) nurse supervisors O and X to update the care plan for a resident who needed EBP. 8. Interview on 3/10/26 at 11:53 a.m. with RN nurse supervisors O and X revealed: *They updated the resident care plans. *They assumed that resident 84 needed EBP with his abdominal drain. *They would notify LPN L if a resident needed EBP to be placed. *They agreed resident 84's care plan did not include EBP or his abdominal drain. *They updated the Kardex and added the EBP for the residents who needed it. *They had added EBP to the Kardex on 2/27/26 for resident 84. *They should have added EBP and his abdominal drain to resident 84's care plan when he was admitted on 2/26/26. 9. Interview on 3/11/26 at 9:22 a.m. with RN H revealed: *She worked the overnight shift at the facility from 7:00 p.m. to 7:00 a.m. *She contacted RN nurse supervisor O and X if there	F0657		

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F0657 SS = D	Continued from page 42 were changes to be made to a resident's care plan. *She did not make changes to resident care plans. *She did have EBP supplies for newly admitted resident if she noticed they were not placed. *She was not aware resident 84 had an abdominal drain. *She only worked in resident 84's hallway if she was called in. *She was aware that EBP sign and supplies were not placed on resident 84's door until 3/9/26. 10. Interview on 3/11/26 at 10:45 a.m. with RN/Minimum Data Set (MDS) Coordinator C revealed: *Resident 84 admitted on 2/26/26 with an indwelling drainage device. *She or RN supervisors O and X would add EBP to resident care plans. *The EBP was missed when resident 84 was admitted to the facility on his 2/26/26 admission UDA. *She would expect EBP to be started upon admission for a resident that had a catheter, indwelling devices, or wound care orders. *She agreed EBP had not been started until 3/9/26. 11. Interview on 3/11/26 at 11:30 a.m. with director of nursing (DON) B revealed: *She was the infection preventionist (IP). *The RN supervisors O and X add EBP to the resident care plans and the Kardex that is used by the CNAs. *LPN L is responsible for placing signage and supplies for EBP in resident rooms when an admission occurs. *She expects the EBP would be added for a resident that required it on admission or with a change in orders or care. *She would expect it to be added to resident care plans within a short period of time. *She expected resident 84's EBP to be added to his care	F0657		

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F0657 SS = D	Continued from page 43 plan before 3/9/26. 12. Review of resident 10's EMR revealed he was admitted to the facility on 5/12/22. His diagnoses included bipolar disorder (a mental condition causing extreme shifts in mood, energy, and activity levels), anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and adjustment disorder with depressed mood. He had a level I (1) Pre-Admission Screening and Resident Review (PASRR) completed on 12/27/23 and again on 10/16/24 due to a potential change in his mental status. The 12/27/23 and 10/16/24 Level I PASRRs stated, "Your Level I screen was submitted for a potential status change. It shows that you have evidence of serious mental illness or an intellectual/developmental disability (IDD). However, your condition does not require further PASRR evaluation at this time because your serious mental illness or IDD treatment needs have not significantly changed since your previous PASRR Level II evaluation." There was no documentation that his 1/29/26 revised care plan included his PASSR recommendations. 13. Interview on 3/11/26 at 11:36 a.m. with DON B revealed that social services designee (SSD) F completed the PASRR screenings, and RN/MDS coordinator C completed the MDS (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs). She was unaware that resident 10's PASSR information was not included in his care plan. She was unsure who was responsible for updating resident 10's care plan because resident care plans could be updated by RN/MDS coordinator C, SSF F, or the unit nurse managers. 14. Interview on 3/11/26 at 12:48 p.m. with SSD F revealed she completed PASSR screenings, and RN/MDS coordinator C completed the MDS. She stated she should have included resident 10's PASSR information in his care plan, and that she was just learning. 15. Interview on 3/11/26 at 4:23 p.m. with administrator A revealed she expected SSD F to complete	F0657		

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F0657 SS = D	Continued from page 44 the PASSR screening and to communicate with RN/MDS coordinator C for accurate coding on the MDS. She expected RN/MDS coordinator C and SSD F to work together to ensure resident care plans were updated and accurate. 16. Review of resident 32's MDS assessment revealed that resident 32 was receiving hospice services. 17. Review of resident 32's EMR revealed his 1/28/26 BIMS assessment score was zero, which indicated his cognition was severely impaired. His EMR included a hospice care plan and hospice notes starting 1/21/26, the date of the resident's hospice admission. 18. Review of resident 32's care plan revealed that the hospice care plan was not incorporated into the resident's facility care plan that was used by the facility staff. 19. Interviews on 3/11/26 between 8:45 a.m. and 9:30 a.m., with CNA Y, M, V, and RN H revealed that the staff used the pocket care plans (a document that identifies residents' care needs and interventions) to know what care they needed to provide the residents. 20. Review of the pocket care plans revealed that they did not include information regarding resident 32's hospice care plan goals or interventions. 21. Interview on 3/11/26 at 12:30 p.m. with RN nurse supervisor X revealed that the facility care plan should have been updated to include the hospice care plan when it was initiated. 22. Review of the provider's revised 5/14/25 Care Plan policy revealed "Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence."	F0657		
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with	F0684	1.No immediate corrective action could be taken for resident 30's call light not being answered timely resulting in urinary incontinence. No immediate corrective action could be taken for resident 82's call light not being answered timely resulting in her pain not being addressed promptly. All residents are at risk for their call lights not being answered timely to ensure their care needs are met promptly. 2. The Administrator, DON, and IDT, in collaboration with the medical director, will review the Call Light policy to ensure that there is prompt response to the residents' call for assistance to ensure their needs are met. The Administrator	April 14, 2026

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F0684 SS = G	Continued from page 45 professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on the interview, record review, call light log documentation review, and policy review, the provider failed to ensure staff responded promptly to two of four sampled residents (30 and 82) who indicated they had concerns with the call lights not being answered in a timely manner. Resident 82 reported being in pain while waiting for her call light to be answered, and Resident 30 reported urinary incontinence when having to wait for her call light to be answered. Findings Include: 1. Interview on 3/8/26 at 2:03 p.m. and 3/9/26 at 10:42 a.m. with resident 30 revealed she had concerns that the facility was short of staff, staff were quitting, and the facility needed to use contracted travel staff. She had concerns that her call light sometimes was not answered quickly enough, causing her to incontinent of urine. 2. Review of resident 30's electronic medical record (EMR) revealed her 3/3/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated she was cognitively intact. She had physician orders on 4/4/25 for oxybutynin chloride 10 milligrams (mg) daily (a medication used to treat frequent urination, urgency, and incontinence). She had diagnoses of reduced mobility, urinary incontinence (involuntary urine leakage), and urinary tract infection. Resident 30's 1/26/26 care plan revealed she required the assistance of one staff member to use the bathroom. 3. Review of resident 30's call light response time report (a report that indicated how long a call light was on before it was turned off) revealed that on 2/25/26 at 1:38 p.m. her call light was on for 16 minutes (min) and 53 seconds (sec), and at 5:00 p.m. for 15 min and 51 sec. On 3/1/26 at 9:29 p.m. her call light was on for 16 min and 41 sec. On 3/4/26 at 9:28	F0684	or designee will educate all staff on the Call light policy to ensure response to activated call lights to provide prompt assistance to meet the residents' needs. Additionally, the Administrator or designee will complete a competency of staff knowledge for all staff on their responsibility of prompt response to resident calls lights. Education and competencies will be completed no later than April 14, 2026. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 3. The Administrator or designee will audit 5 residents' call light log report to ensure response to activated call lights to provide prompt assistance to meet the residents' needs. Additionally, the Administrator or designee will interview 5 residents to ensure their care needs were met when their call light was answered by staff. These audits and interviews will continue for four weeks and then monthly for three months. Results of audits and interviews will be reviewed by the Administrator with the IDT and Medical Director at monthly QAPI for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	

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F0684 SS = G	Continued from page 46 p.m. her call light was on for 26 min and 28 sec. On 3/6/26 at 7:04 p.m. her call light was on for 28 min and 4 sec. On 3/8/26 at 7:06 a.m. her call light was on for 26 min and 5 sec. 4. Interview on 3/8/26 at 2:15 p.m. and 3/11/26 at 11:30 a.m. with resident 82 revealed that she waited up to an hour for her call light to be answered when requesting assistance to the bathroom or for pain medications. She feels upset and as if the staff have forgotten about her when she had to wait a long time for her call light to be answered. She stated she was in pain since she had to wait for pain medications. 5. Review of resident 82's EMR revealed her 3/5/26 BIMS assessment score was 14, indicating she was cognitively intact. Resident 82 had diagnoses of unspecified depression, and multiple fractured ribs on her right side. 6. Review of resident 82's medication administration record (MAR) revealed that resident 82 was given an as needed (PRN) oxycodone HCl 5mg tablet for pain on 3/4/26 at 7:39 p.m., 3/7/26 at 6:02 a.m., 3/7/26 at 2:15 p.m., and on 3/7/26 at 10:10 p.m. 7. Review of the call light report from 2/23/26 through 3/8/26 revealed resident 82 had nine call response times greater than 15 minutes. Resident 82's call light response times revealed on 3/4/26 at 3:54 p.m. her call light was on for 27 minutes, on 3/4/26 at 7:01 p.m. her call light was on for 25 minutes, on 3/5/26 at 11:21 p.m. her call light was on for 20 minutes, on 3/6/26 at 3:25 p.m. her call light was on for 20 minutes, on 3/7/26 at 4:42 a.m. her call light was on for 36 minutes, on 3/7/26 at 5:27 a.m. her call light was on for 33 minutes, on 3/7/26 at 1:29 p.m. her call light was on for 39 minutes, on 3/7/26 at 3:19 p.m. her call light was on for 16 minutes, and on 3/7/26 at 9:24 p.m. her call light was on for 27 minutes. 8. Interview on 3/9/26 at 8:57 a.m. with CNA T revealed CNAs knew a call light was on because it could be heard from the hallway, and a light was visible above the resident's doorway. It would alert on a pager that the staff were to carry. He did not have a pager and stated he should have.	F0684		

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F0684 SS = G	Continued from page 47 9. Interview on 3/9/26 at 10:48 a.m. with LPN N revealed pagers were locked up in the medication room, and the nurses had to check them out to the CNAs. The CNAs had to give them a personal item to temporarily exchange for the pager. Some staff did not want to do that, so some CNAs did not carry a pager. 10. Interview on 3/10/26 at 9:37 a.m. with CNA DD revealed she was a contracted travel CNA. This was her second shift here at the facility, and she did not know the facility had pagers. 11. Interview on 3/11/26 at 8:45 a.m. with CNA Y revealed the facility would like the call lights answered in under 5 minutes. 12. Interview on 3/11/26 at 9:05 a.m. with CNA M revealed that the call lights should be answered within a timely manner of no more than 15 minutes. 13. Interview on 3/11/26 at 9:30 a.m. with registered nurse (RN) H revealed that the call lights should be answered as quickly as possible but no more than 15 minutes. 14. Interview on 3/11/26 at 11:35 a.m. with director of nursing (DON) B revealed that the call lights should be answered in under 15 minutes. 15. Review of the provider's reviewed 11/18/2025 Call Light policy revealed the "facility shall answer call lights in a timely manner."	F0684		
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	F0689	"Past Noncompliance - no plan of correction required"	

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F0689 SS = G	Continued from page 48 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), observation, interview, record review, and policy review, the provider failed to ensure the safety of one of one sampled resident (7) who eloped (left the facility without staff knowledge) from the front door of the facility on 9/2/25, and one of one sampled resident (77) who fell while being transferred by certified nursing assistant (CNA) V, who did not transfer the resident as directed in the resident's care plan (personalized plan that addresses a resident's care needs, goals, and interventions). This citation is considered past non-compliance based on a review of the provider's corrective actions immediately following the incidents. Findings Include: 1. Review of the provider's 9/3/2025 SD DOH FRI revealed on 9/2/25 at 2:48 p.m. resident 7 exited the building following a staff member leaving the property. Resident 7 was seen outside in the parking lot by the front door at 2:50 p.m. and escorted back into the facility. A skin assessment, blood pressure, pulse, temperature, and respirations were taken by registered nurse (RN) K on 9/2/25 upon resident 7 entering the facility. The staff education on the elopement policy and where the elopement photographs (photographs taken and displayed of residents who are a high risk for leaving the facility) were located was initiated. Elopement audits were started on 9/9/25 and reviewed in Quality Assurance and Performance Improvement (QAPI) meeting. Staff were aware of which residents were at risk of elopement. Resident 7's care plan and elopement risk assessments were reviewed. Her primary care provider (PCP) and family were notified of the incident. 2. Review of resident 7's electronic medical record (EMR) revealed that her Brief Interview for Mental Status (BIMS) score on 8/6/25 was three and on 1/26/26/26 was zero, which both indicated her cognition was severely impaired. Resident 7's 7/3/25 and 9/2/25 elopement risk assessments' scores were 5, which indicated she had a high risk for elopement. 3. Resident 7's care plan in use prior to the elopement revealed non-pharmaceutical (no medications)	F0689		

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F0689 SS = G	Continued from page 49 interventions for when resident was wandering. Interventions initiated on 8/28/24 were to cue, reorient and supervise resident 7. Interventions added to her care plan on 3/5/25 were the use of animatronic dog, conversation, walking with resident, inviting her to activities, encouraging rest and providing less stimulation when exhibiting anxious behaviors, delusions or wandering. Interventions added to her care plan on 9/2/25 identified resident 7 as an elopement risk due to diagnosis of dementia and delusional disorders with additional interventions that include exit and stairwell alarms, follow a familiar routine, keep photographs of resident on the unit and at the front desk, redirect the resident with familiar pictures and items, and maintain a calm environment. Interventions added on 1/19/26 resident 7's visitors would notify staff when they leave her room so staff will know resident 7's whereabouts within the facility. 4. Resident 7's progress notes revealed at the time of the elopement on 9/2/25, she was ambulating with a walker throughout the facility. 5. Observation on 3/8/26 at 6:35 p.m. of resident 7 revealed she was maneuvering around the dining room in a wheelchair. 6. Observation on 3/10/26 at 8:57 a.m. with receptionist BB revealed that anytime a new resident showed signs of possible elopement risk, staff posted a picture at the front desk and in the time clock room where staff clock in and out for the day. 7. Observation on 3/10/26 at 9:00 a.m. revealed that residents who are at risk for elopement had photos laminated on a sheet of paper in the time clock room and at the front desk. 8. Interviews on 3/11/26 at 8:45 a.m. to 9:30 a.m. with certified nursing assistants (CNA) (Y, M, V) and RN H revealed they identified elopement-risk residents by using the pictures in the time clock room, and the pocket care plans (a document that identifies residents' care needs and interventions) that say if they were an elopement risk. 9. Interview on 3/11/26 at 3:00 p.m. with director of nursing (DON) B revealed she did not consider resident 7's elopement a lack of staff supervision. She stated, "the residents are mobile and deemed an elopement risk,	F0689		

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F0689 SS = G	Continued from page 50 but if they were to get outside that it is an elopement based on our policy." She expected staff to know the photos of the residents and which residents were high elopement risks. She expected staff to respond to door alarms immediately and if there was an elopement she expected the staff to call her immediately. DON B stated that during resident 7's elopement, the staff member let in five family members into the front door, which crowded the direct sight of receptionist at the front desk from seeing resident 7 use her walker to leave the facility. 10. Review of the provider's staff education provided on 9/2/25 revealed that all staff received education on the elopement policy, including the expectation that staff know which residents were in the area of the exit door when they were leaving the facility for any reason, and that they ensure the door closes behind them once they exited the building. 11. Review of the provider's quality assurance and performance improvement (QAPI) notes from October 2025 revealed the elopement for resident 7 was being monitored. 12. Review of the provider's audits after resident 7's elopement revealed weekly audits of four staff members or visitors that were exiting the building were visually checked to ensure no resident followed them from the building. Audits were completed over the course of four weeks from 9/9/25-9/30/25. All 28 audits were documented to show the doors were being monitored by staff and visitors when they were exiting. 13. Review of the provider's February 2024 Elopement policy revealed "The facility must take steps to keep the resident safe and assess residents to identify those who are risk for elopement." 14. The provider implemented actions to ensure the deficient practice did not reoccur. On 3/12/26, observation, interviews, and record review confirmed the facility had followed its quality assurance process. The facility provided education to all nursing staff regarding the elopement policy, and the elopement photographs were placed at the front reception desk and the time clock room. Staff interviews showed they understood the education provided. The facility completed audits demonstrating staff knowledge of expectations when exiting the facility and awareness of residents at risk for elopement and their surroundings. The QAPI committee was monitoring the progress of the audits as noted in their meeting documentation.	F0689		

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F0689 SS = G	Continued from page 51 15. Based on the information above, non-compliance at F689 occurred on 9/2/25. Because the provider implemented corrective actions from 9/2/25 through 9/30/25, and those actions were confirmed on 3/12/26, the non-compliance is considered past non-compliance. 16. Review of the provider's 11/25/25 SD DOH FRI for resident 77 revealed that on 11/11/25 at 8:00 a.m., licensed practical nurse (LPN) I was called to resident 77's room by CNA V. Resident 77 was lying on her right side on the floor at the foot of her bed. CNA V reported he had been assisting resident 77 from the bathchair to her wheelchair when "she was unable to stand any longer" and he "eased" her to the floor. LPN I "immediately assessed" resident 77 and found a one-centimeter skin tear to her right eyebrow that was closed with a "steri-strip [an adhesive strip used to close small, shallow wounds]," and a light blue bruise that measured ten centimeters by three centimeters on her right upper arm. Resident 77's range of motion was at "baseline", and her neurological assessments (an assessment of nerve function, reflexes, coordination, motor skills, sensation, and mental status) and vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) were within normal limits. Resident 77 complained of pain at 3 on a scale from 0 (no pain) to 10 (worst imaginable pain). Pain medication was provided, and an icepack was applied to resident 77's arm. Resident 77's care plan indicated she was to be transferred by one-person assist with a gait belt (a waist strap gripped as support for safe mobility and transfers). CNA V did not use a gait belt when he transferred resident 77 and was suspended immediately. The provider's interdisciplinary team (IDT) met following resident 77's fall and reviewed her care plan, which remained appropriate. Education regarding gait belts and the provider's Transfer Gait Belt Use policy was initiated with all staff members on 11/25/25. "Audits will be conducted on [CNA V] weekly x [for] 4 weeks and 3 random residents weekly x 4 weeks." Residents 77's primary care physician and power of attorney were notified. 17. Review of resident 77's EMR revealed she was admitted to the facility on 8/13/25. Her 8/13/25 care plan indicated she transferred with one person's assistance using a walker and a gait belt. Her 8/13/25 Fall Risk Evaluation indicated she was at a high risk	F0689		

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F0689 SS = G	Continued from page 52 for falling. 18. Interview on 3/10/26 at 1:10 p.m. with CNA V revealed that he recalled the events of resident 77's 11/25/25 fall and confirmed the information reported in the FRI was accurate. He knew that he needed to use a gait belt when he transferred resident 77 from the bath chair to the wheelchair, and was unsure why he had not used one that day. He received education on resident care plans, the use of gait belts, and safe transfers with residents. 19. Interview on 3/10/26 at 1:10 p.m. with DON B revealed resident 77's fall occurred because CNA V did not follow the resident's care plan, which included that she needed to be transferred with a gait belt. Education was provided to all caregiver staff on following the resident care plans, the use of gait belts, and safe transfers with residents. Audits were started and completed weekly on CNA V and other staff members when transferring residents to ensure that resident care plans were followed, and gait belts were used when required. A QAPI meeting was held on 12/3/25 and included resident falls, including resident 77's 11/11/25 fall, safe resident transfers, and ensuring transfer status and equipment were included in the resident care plans. 20. Interview on 3/11/26 at 4:19 p.m. with administrator A regarding resident 77's 11/25/25 fall revealed that she confirmed they immediately suspended CNA V, reported the incident to the SD DOH, resident 77's physician, and the resident's power of attorney, and conducted an investigation. They identified that CNA V had not used a gait belt, as indicated in her care plan, when he transferred resident 77 that day, and she fell. They provided immediate education to CNA V and initiated education with all caregiver staff members on 11/25/25. They completed weekly audits of CNA V and other staff members completing transfers. They included those audits in their QAPI program and are continuing to monitor falls throughout the facility. 21. Review of the provider's Transfer and Gail Belt Use, Care Plan, and Falls Management policy staff education initiated on 11/25/25 revealed that all staff were educated.	F0689		

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F0689 SS = G	Continued from page 53 22. Review of the provider's QAPI notes from 12/3/25 revealed that resident falls, including resident 77's 11/25/25 fall, were reviewed, and a gait belt performance improvement project (PIP) had been initiated. 23. Review of the provider's audits after resident 77's 11/25/25 fall revealed the provider completed three audits a week for four weeks, and no further issues were observed. Care plans were followed, including the use of the gait belt, and further education was provided to staff members when needed. 24. The provider's implemented actions to ensure the deficient practice does not recur were confirmed on 3/12/26 after record review revealed the facility had followed their quality assurance process, education was provided to all nursing staff regarding care plans, the use of gait belts, and the provider's fall management policy, and audits were completed. Interviews with nursing staff revealed they understood the education provided regarding the resident safety with transfers, the use of gait belts, and following the resident care plan. Observations of transfers in residents' rooms were conducted, and confirmed that staff understood how to use gait belts, followed the resident care plan, and transferred residents safely. A QAPI meeting was held on 12/5/25 to implement a plan, and will continue to be a part of their QAPI process for review and further advise staff as needed. 25. Based on the above information, non-compliance at F689 occurred on 11/25/25, and based on the provider's 12/5/25 implemented corrective actions for the deficient practice confirmed on 3/12/26, the non-compliance is considered past non-compliance.	F0689		
F0710 SS = E	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs.	F0710	1. Resident 57's physician was notified of resident's unplanned significant weight loss on March 10, 2026, upon discovery during the annual recertification survey. Resident 61's physician was notified of resident's unplanned significant weight loss on March 13, 2026. All residents with a significant weight loss are at risk of their physician not being notified of their weight loss. A full house audit will be completed to ensure all residents' physicians have been notified if a resident has exhibited an unplanned significant weight loss. 2.The DON or designee will educate all licensed nurses on the Weighing the Resident and the Notification of Change of	April 14, 2026

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F0710 SS = E	Continued from page 54 §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the provider failed to notify the physician of two of three sampled residents (57 and 61) who had unplanned significant weight loss (a loss of 5% (percent) of body weight in 30 days, 7.5% in 90 days, or 10% in 180 days). Findings include: 1. Interview on 3/8/26 at 2:35 p.m. with resident 61 in her room revealed that she was unhappy with the food. She stated she lost weight since she admitted to the facility about one month ago because the food gave her diarrhea and was "inedible" and "disgusting." She had not met with the dietitian or the doctor about her concerns with the food or her weight loss. She ate all her meals in the dining room. She was frustrated that her daughters would not let her return home and felt that she was "in a cage." She stated that she had attempted multiple times to leave the facility but that staff members had prevented her from doing so. 2. Observation on 3/8/26 at 5:37 p.m. with resident 61 in the dining room revealed that she walked independently to the dining room, asked what was for dinner, and stated, "It sounds good." Resident 61 stated, "This looks good," when she was served her meal, moved the food around on her plate, removed the beans from her soup, took a couple of small bites of the broth, and drank a few sips of water. When a staff member encouraged her to eat, resident 61 stated she had eaten all she wanted and declined the staff's offer of other food items. 3. Interview on 3/8/26 at 6:19 p.m. with resident 61	F0710	Condition policies to ensure residents' physicians are notified of any unplanned significant weight loss. Education will be completed no later than April 14, 2026. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 3.The DON or designee will audit 5 residents' weights to identify if they have had an unplanned significant weight loss and that their physician has been notified if indicated. These audits and interviews will continue for four weeks and then monthly for three months. Results of audits and interviews will be reviewed by the Administrator with the IDT and Medical Director at monthly QAPI for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	

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F0710 SS = E	Continued from page 55 revealed that she stated the food was "awful." She then stated that her stomach was "awful" and the food was "fine." She stated that she did not want to eat any food and that she was afraid she would have diarrhea. 4. Observation and interview on 3/10/26 at 8:21 a.m. with resident 61 in the dining room revealed she was served hot tea, milk, juice, hot cereal, an egg sandwich, and a banana. She stated the breakfast was "good." She moved food items around on her plate but was not observed to eat any of the food. 5. Review of resident 61's electronic medical record (EMR) revealed she was on a regular diet with mechanical soft textures and a Nutrition Intervention Plan (NIP). Her care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated to monitor her for difficulty chewing or swallowing, signs and symptoms of dehydration, and weight loss. Staff members were to obtain her weight every week and to monitor and record her intake at every meal. Resident 61's admission weight on 2/9/26 was 173.4 pounds (lbs). On 2/16/26, her weight was 154.4 lbs. That was a 19 lb. weight loss in seven days. On 2/23/26, her weight was 153.3 lbs. That was a 0.9 lb. weight loss in seven days. On 3/2/26, her weight was 146.4 lbs. That was a 7.1 lb. weight loss in seven days. On 3/9/26, her weight was 142.6 lbs. That was a 3.8 lb. weight loss in seven days. Resident 61 had lost 30.8 lbs. since her admission, a 17.8% (percent) weight loss. There was no documentation that resident 61 had been reweighed or refused to be weighed when there was a documented weight loss. There was no documentation that physician FF was notified of resident 61's weight loss. Resident 61 had been at the facility for 27 days. She was documented as refusing to eat 13 meals, had eaten 0-25% at 16 meals, and there was no documentation of how much resident 61 had eaten or if she refused for 19 meals. 6. Interview on 3/10/26 at 8:37 AM with certified nursing assistant (CNA) P in the dining room revealed she was responsible for recording the amount of food and liquid each resident in the dining room ate and drank that day. The CNAs took turns completing that task depending on who was working and who was in the dining room. Those amounts were to be recorded in the	F0710		

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F0710 SS = E	Continued from page 56 residents' EMR. She thought that resident 61 ate "pretty well," did not complain about the food, and had never asked for or accepted substitute food items from her. For breakfast, when she looked at resident 61's plate after she left the dining room, CNA P stated it appeared that resident 61 had not eaten very much. CNA P stated that resident 61 had moved the food around on her plate, but she was unsure if resident 61 had eaten anything. She would mark zero to 25 percent (0-25%) in resident 61's EMR because resident 61 had not refused to come to the dining room. CNA P stated that she was unaware of whether resident 61 had experienced weight loss since her admission to the facility. She did not weigh residents because the bath aide weighed the residents. She did not notify the nurse regarding the amount resident 61 ate because she thought the EMR alerted the nurse when a resident ate less than 50% of their meal. 7. Interview and review of the bath and weight sheets on 3/10/26 at 8:44 a.m. with CNA T revealed he was the bath aid. The bath and weight sheets indicated which residents were to receive a bath and have their weight taken that day, and which residents needed to be reweighed. Those weight sheets indicated the residents' last weight, and he would record the resident's current weight on those sheets and in the resident's EMR. He would provide the completed sheet to the nurse at the end of his shift. If he noticed a weight loss of more than three pounds (lbs.), he would reweigh the resident and tell the nurse. Resident 61 was scheduled for a bath and a weight check on 3/10/26. She refused the bath, but he weighed her. He was aware that resident 61 had lost weight, and he had notified the nurse. He offered her many different food items, but she refused to eat. 8. Interview on 3/10/26 at 8:57 a.m. with licensed practical nurse (LPN) W revealed she had recorded resident 61's weight in the EMR when she admitted about a month ago, but the CNA that day had weighed her. She recalled that resident 61 was in a wheelchair when her weight was taken, and the CNA subtracted the weight of the wheelchair before she entered the weight in the EMR. She was aware that resident 61 was refusing to eat	F0710		

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F0710 SS = E	Continued from page 57 until she was allowed to discharge to her home, and had a significant weight loss since her admission to the facility. She thought that resident 61's physician was aware of the resident's weight loss. She did not notify resident 61's physician of the weight loss because she was not assigned to be resident 61's nurse on 2/16/26 or 2/23/26 when she was weighed. She expected that the nurse on duty that shift would have notified the physician. 9. Observation and interview on 3/10/26 at 9:30 a.m. with LPN N revealed she was aware that resident 61 had a weight loss since her admission to the facility because she was on a "hunger strike." She thought that staff members were able to get resident 61 to eat a few things. She did not notify physician FF of resident 61's weight loss because she thought that resident 61 told physician FF she was refusing to eat when he was at the facility to see her. When a resident had a three-pound weight loss, the resident would be reweighed, and the physician would be notified. 10. On 3/10/26 at 9:35 a.m., administrator A was requested to provide documentation of resident 61's weights and reweighs, and documentation that the physician was notified of resident 61's weight loss. Resident 61's weekly weights were provided. There was no documentation of resident 61 having been reweighed or that the resident's physician was notified regarding resident 61's weights. 11. Observation and interview on 3/9/26 at 9:00 a.m. with resident 57 revealed she had a few teeth left in the front that were broken, making it hard for her to chew certain foods. She did not want to go to the dentist, and she did not want a specialized diet. 12. Review of resident 57's medical record revealed her weight on 3/4/26 was 133.7 lbs, and on 3/8/26, was 125.4 lbs. In one month, her weight was down 5%. Review of resident 57's diet intakes for the past 30 days indicated she ate 26-50% of her meals 28 times, and 51-75% of her meals 22 times. She had physician orders on 2/23/23 for 4 ounces (oz) of a nutritional supplement daily at breakfast, on 1/25/25 for ice cream daily at supper, and on 12/23/24	F0710		

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F0710 SS = E	Continued from page 58 for a regular diet with regular texture. Resident 57's 2/27/26 care plan revealed she had a history of weight loss and nutrient deficiencies. She had poor dentition but was still able to eat a regular diet, and the staff were to monitor her for weight loss. Resident 57's 2/6/26 Brief Assessment for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. A 1/6/26 dietitian note by registered dietitian (RD) CC did not address resident 57's difficulty chewing certain foods related to her teeth. There was no progress note to indicate that resident 57's physician was notified of her weight loss. 13. Interview on 3/10/26 at 9:50 a.m. with LPN N revealed resident 57 had difficulty eating certain foods, did not want to see a dentist, and did not want her diet changed. If a resident's current weight was three to five pounds different from the previous weight, she would have the staff reweigh the resident. If that weight had a three to five pound difference, then the registered dietitian (RD) and physician were to be notified. She was not sure who was supposed to notify the RD, but the nurse was to notify the physician. 14. Interview on 3/11/26 at 9:27 a.m. with RD CC revealed she was at the facility on Tuesday and Thursday each week, but was on vacation during the week of 2/18/26. Each week, she attended a meeting with registered nurse (RN) supervisor O and X to discuss the residents' weights. All residents who experienced weight loss were discussed. If the CNAs noticed a change in the residents' weight, they were to tell the nurse supervisors. The nurse supervisors were to request a reweigh within 24 hours, and she stated, "I am not sure if that happens every time." She ran a weight report weekly, and if she noticed a resident's weight changed, she would request a reweight. If a resident had a notable change in weight, the nurse supervisors were to notify the physician right away, and could add them to the physician rounds (when the physician comes to the nursing home to see	F0710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

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F0710 SS = E	Continued from page 59 the resident) list if they needed to be seen. Changes in the residents' weight should not wait to be followed up on at their weekly meeting. Regarding the 8.3 lb. weight loss for resident 57, RD CC stated that RN supervisor O should have followed up with her weight loss. She was aware that resident 61 had a significant weight loss in the month since her admission because she was eating very little. She asked for resident 61 to be reweighed during the weeks of 2/9/26 and 3/2/26, but was unaware if those weights were obtained. Resident 61 was placed on a nutrition intervention program (NIP) where extra nutrients were added to hot cereal, vegetables, and potatoes, and residents were provided with whole milk and ice cream. Resident 61 had also been offered a supplement, chocolate milk, and ice cream. She had not been aware that resident 61 had told staff she was on a hunger strike. She confirmed that resident 61's 30 lb. weight loss was "very significant," but resident 61's BMI was 24.5 and considered within the normal range. She expected that physician FF and resident 61's family would be notified by the facility staff members of her weight loss, but was unsure if those notifications occurred. She expected meals to be recorded three times a day, even if a resident refused to eat. 15. Interview on 3/11/26 at 9:40 a.m. and again at 10:09 a.m. with RN nurse supervisor O revealed that the CNA was to notify the charge nurse if a resident's weight was different by three to five lbs. The charge nurse would then have the CNA complete a reweigh. If the reweigh indicated the resident had an eight lb weight loss, then the charge nurse was to notify the resident's physician. The bath aides turned in their bath sheets, which contained the residents' weights documented on them, at the end of the day for the nurse to review. The nurse then was to give them to the case managers to review. Regarding resident 61's weight loss, RN nurse supervisor O revealed that resident 61 had not been eating very much since she was admitted to the facility. She reviewed resident 61's weights each week when she met with RD CC since she was admitted to the facility. Resident 61 was not happy about being at the facility, attempted to leave the facility, refused to eat, and refused to go to the dining room at times. Resident 61 was on a "hunger strike."	F0710		

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F0710 SS = E	Continued from page 60 She thought physician FF was aware of all resident 61's behaviors since she was admitted. She had not notified physician FF of resident 61's weight loss, but thought that he was aware because physician FF visited resident 61 at the facility. She expected resident 61 to have been reweighed on 2/17/26 and on 3/3/26. She was unsure if those reweighs had been obtained or if resident 61 had refused to be weighed. 16. Interview and review of bath sheets and resident 61's EMR on 3/11/26 at 10:44 a.m. with director of nursing (DON) B revealed she expected resident 61 to be reweighed if she had a weight loss of more than three pounds since her previous weight. There was no documentation that resident 61 had been reweighed after she was weighed on 2/16/26 or 3/2/26. DON B became aware of resident 61's weight loss on 3/4/26. She expected that resident 61's physician would have been notified after her 2/16/26 weight loss and again after the 3/2/26 weight loss. There was no documentation that physician FF had been notified. 17. Phone interview on 3/11/26 at 11:08 a.m. with physician FF revealed that he noticed a downward trend in resident 61's weight when he visited her at the facility. He was not notified of that weight loss by the nurses at the facility. He was addressing resident 61's behavior and mood issues. He was aware that resident 61 did not want to be at the facility, attempted to leave the facility several times, and that she was not eating well. He expected to be notified if a resident had a 10% weight loss. He was notified on 3/10/26 that resident 61 was on a hunger strike. He felt there were many issues that contributed to resident 61's weight loss. On 3/6/26, resident 61 had told him she was having difficulty swallowing, and he ordered a swallow study, which was scheduled for 3/16/26. He had a scheduled meeting on 3/13/26 with resident 61, her family, and facility staff to discuss her discharge plan and possible psychiatric consultation. 18. Review of the provider's 5/14/25 Weighing the Resident policy revealed "If weight does not appear correct, re-weigh [the] resident to ensure [the] weight is accurate. Consider re-weighing the resident if there is a 5[five]-pound difference from the resident's last weight."	F0710		

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F0710 SS = E	Continued from page 61 "Report significant weight loss/ weight gain to the charge nurse who will then report to the RD and [the] physician." "The threshold for significant unplanned and undesired weight loss/gain will be based on the following criteria… 1 [One] month- 5% weight loss is significant; greater than 5% is severe. 3 [Three] months – 7.5% weight loss is significant; greater than 7.5% is severe. 6 [Six] months – 10% weight loss is significant; greater than 10% is severe. "Notify the charge nurse if the resident refuses to be weighed. Document [the refusals in the medical record and reapproach [the] resident as needed. Notify [the] physician if [the] resident refuses three consecutive attempts to weigh." 19. Review of the provider's revised 11/18/25 Notification of Change of Condition policy revealed, "The facility must promptly inform the resident; consult with the resident's medical provider…when… A significant change in the resident's physical, mental, or psychosocial status… Continued resident refusals of ordered treatments or procedures 9at least three consecutive refusals)."	F0710		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F0812	1.Cook GG was educated immediately upon discovery during the annual recertification survey on March 8, 2026, to ensure cold food or drink items were not served to any resident if the temperature of the item was greater than 41 degrees. No residents received a food or drink item that was not at the appropriate temperature during the supper meal service on March 8, 2026. No immediate corrective action could be taken for staff B, C, D, F, O, HH, II, JJ, KK, and LL washing their hands in the dining room kitchenettes with food uncovered, without hair restraints to prevent hair from contacting the food. A sink was installed outside of the kitchenettes in all 3 dining rooms to prevent staff from washing their hands in the dining room kitchenettes where food is uncovered. These were installed effective March 16, 2026. Additionally, hair nets have been made available to staff outside of the kitchenettes in all 3 dining rooms to prevent hair from contacting the food if staff need to enter the kitchenettes. All residents are at risk for adverse effects of not following standard food practices to prevent food-borne illness. 2. The Administrator or designee will educate all dietary staff on the Serving Temperature for Hot and Cold Foods policy to ensure foods are maintained within the appropriate temperature for serving to prevent food-born illnesses. The Administrator or designee will educate all staff responsible for serving meals in the dining room, including staff B, C, D, F, O,	April 14, 2026

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F0812 SS = F	Continued from page 62 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to follow standard food safety practices to ensure: *Food was maintained at a safe temperature to prevent food-borne illness for one of two observed meal services in one of two dining rooms (Independence). *Ten of eleven observed staff (B, C, D, F, O, HH, II, JJ, KK, and LL) who washed their hands in the Independence kitchenette with food uncovered, without hair restraints to prevent hair from contacting the food, during an observed supper meal service. *Four of five observed staff (C, G, NN, OO) who washed their hands in the Nixon kitchenette with food uncovered, without hair restraints to prevent hair from contacting the food during an observed lunch meal service. Findings include: 1. Observation of the supper food service on 3/8/26 in the Independence kitchenette revealed that at 5:53 p.m., cook GG arrived at that kitchenette with a cart that had a container of pre-made egg salad sandwiches, which sat on a container of ice. Cook GG took the temperature of the egg salad sandwiches, and they were 45 degrees Fahrenheit (F). Beginning at 5:55 p.m., staff members periodically went behind the kitchenette to wash their hands in the sink when uncovered food was in the steam table and on the cart, and they were not wearing hair nets or hair restraints. Those staff included certified nursing assistant (CNAs) D, HH, JJ, KK, and LL, certified medication assistant (CMA) II, registered nurse (RN) supervisor O, RN/Minimum Data Set (MDS) coordinator C, director of nursing (DON) B, and social service designee (SSD) F. Some of those staff members had touched the cart that had egg salad sandwiches on it with their backs while washing their hands in the sink. At 6:05 p.m. cook GG began plating the egg salad	F0812	HH, II, JJ, KK, and LL) on the Hair Restraint policy to ensure hair restraints are used if entering the kitchenettes in the dining rooms to prevent hair from contacting food. Additionally, the Administrator or designee will educate all staff responsible for serving in the dining rooms to utilize the hand sinks that have been installed outside the kitchenettes to perform hand hygiene to ensure standard food practices are being followed. Education will be completed no later than April 14, 2026. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 3. The Administrator or designee will audit 5 meal services to ensure the temperature of food items being served are within the appropriate temperature range for serving to prevent food-borne illnesses. The Administrator or designee will audit 5 staff serving meals in the dining rooms to ensure they are performing hand hygiene at the sinks outside the kitchenettes and that a hair net is donned if needing to enter the kitchenette to prevent hair from contacting food. Audits will be completed weekly for 4 weeks and then monthly for 2 months. Results of audits will be discussed by the Administrator or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F0812 SS = F	Continued from page 63 sandwiches to serve to the residents. When asked, she stated the egg salad sandwiches were to be at 41 degrees F or less, so she should not serve them. She retook the temperature of the egg salad sandwich, and it was 50 degrees F, and stated that all the ones she checked were above 41 degrees F. She called dietary manager (DM) Q, and she said she would call her back. At 6:14 p.m., someone called her on the phone in the kitchenette and told her not to serve the egg salad sandwiches and to take them back to the kitchen. At 6:23 p.m., she received new egg salad sandwiches, and the temperature of them was 55 degrees F, so they were not served to the residents. At 6:58 p.m., new egg salad sandwiches were brought to the kitchenette, and their temperature was under 41 degrees F, so they were served. At 7:20 p.m., cook GG checked the temperature of the milk on a resident room meal tray that was on the tray since the start of food service. It was 60 degrees F. She said it was to be under 41 degrees F, so she did not serve that and replaced it. At 7:21 p.m., DON B reheated soup in the microwave behind the kitchenette and did not wear a hair net. 2. Interview on 3/8/26 at 7:25 p.m. with cook GG revealed she verified she was going to serve the egg salad sandwiches that were 45 degrees F and the milk that was on the room tray and was 60 degrees F. 3. Observation on 3/9/26 during the lunch food service in the Nixon kitchenette revealed that at 11:59 a.m., the food was in the steam table and was uncovered. SSD G washed her hands in the kitchenette, and she was not wearing a hair net or hair restraint. At 12:01 p.m., staffing coordinator NN washed her hands in the kitchenette, and she was not wearing a hairnet. At 12:02 p.m., medical records director OO washed her hands again in the kitchenette and was not wearing a	F0812		

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F0812 SS = F	Continued from page 64 hairnet or hair restraint. At 12:03 p.m. RN/MDS coordinator C washed her hands in the kitchenette. She wore her hair in a ponytail that did not contain all of her hair, and she did not wear a hairnet or hair restraint. At 12:04 p.m., SSD G washed her hands again in the kitchenette, and was not wearing a hair net or hair restraint. 4. Interview on 3/11/26 at 8:32 a.m. with DM Q revealed she expected the cook to call her if the temperature of the food was not at the required serving temperature. Cook GG should not have started to serve the egg salad sandwich or the milk if it was not at a safe temperature. Staff routinely washed their hands behind the kitchenette, and only dietary staff wore hairnets/hair restraints. 5. Interview on 3/12/26 at 10:25 a.m. with DON B revealed she expected staff to wear hairnets if they were around food that would be served to the residents. 6. Review of the provider's 2020 Serving Temperature for Hot and Cold Foods policy revealed that cold food and dairy products were to be served at 41 degrees or colder to ensure a safe dining experience. 7. Review of the provider's 2020 Hair Restraints policy revealed that "staff shall wear hair restraints in all food production, dishwashing, or serving areas. Hair restraints, hats, and/or beard guards shall be used to prevent hair from contacting exposed food."	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of	F0880	1. Personal Protective equipment (PPE) was made available for staff use for residents 82 and 84 requiring EBP by hanging the PPE on the outside of the residents' doors, along with signage to alert staff of need for PPE upon discovery during the annual recertification survey on March 9, 2026. .....continued on next page	April 14, 2026

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F0880 SS = D	Continued from page 65 communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880	during the annual recertification survey on March 9, 2026. No immediate corrective action could be taken for CNA EE not performing appropriate hand hygiene and not maintaining appropriate infection control practices with the washcloths used during catheter care for resident 20. No immediate correction action could be taken for LPN W not performing hand hygiene between glove use while performing wound care for resident 20. All residents are at risk of adverse effects from staff not following appropriate infection prevention and control practices to maintain infection control. 2.DON or designee will educate all nursing staff on the Enhanced Barrier Precautions policy to ensure PPE is available for staff use to ensure staff follow infection prevention and control practices to maintain appropriate infection control. Additionally, the DON will educate all nursing staff, to include CNA EE and LPN W, on the Hand Hygiene policy which covers glove use, and the Urinary Catheter/Catheter Care/Catheter Associated Urinary Tract Infections (CAUTI) Prevention Policy, to ensure staff follow infection prevention and control practices to maintain appropriate infection control practices. Education will be completed no later than April 14, 2026. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 3.DON or designee will conduct a full house audit of all current residents on EBP, and on all new resident admissions to ensure if EBP is required that PPE is available for staff use and signage is placed on the resident's door to alert staff of EBP requirement and need for appropriate PPE. DON or designee will audit 5 CNAs, to include CNA EE, while performing catheter care to residents to ensure the Urinary Catheter/Catheter Care/Catheter Associated Urinary Tract Infections (CAUTI) Prevention Policy is being followed and to ensure proper hand hygiene is performed and appropriate infection control practices are followed when handling washcloths while providing catheter care to maintain infection control. Additionally, the DON or designee will audit 5 nurses, including LPN W, while performing wound care to ensure hand hygiene is appropriately performed to maintain infection control. Audits will be completed weekly for 4 weeks and then monthly for 2 months. Results of audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F0880 SS = D	Continued from page 66 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed infection prevention and control practices by: *Not having personal protective equipment (PPE) (gloves and gowns) available for staff use for two of two sampled residents (82 and 84) on enhanced barrier precautions (using gowns and gloves during high-contact care to reduce the spread of multidrug-resistant organisms (MDROs) in a nursing home). *One of one observed certified nursing assistant (CNA) (EE) while providing urinary catheter (flexible tubing placed in the bladder to drain urine) care for one of one sampled resident (20). *One of one observed licensed practical nurse (LPN) (G) who did not perform hand hygiene (handwashing) while completing one of one sampled resident's (20) wound care treatment. Findings Include: 1. Observation on 3/8/26 at 2:13 p.m. of licensed practical nurse (LPN) L revealed she was putting up yellow enhanced barrier precautions (EBP) personal protective equipment (PPE) organizers on resident 82's doorway. 2. Review of resident 82's electronic medical record (EMR) revealed she was admitted on 3/3/26 with an indwelling Foley catheter. She had a 3/3/26 physician's order to monitor and record her foley catheter output three times daily (TID). Her Minimum Data Set (MDS) (a	F0880		

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F0880 SS = D	Continued from page 67 tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessment, completed on 3/3/26, indicated in Section X that she was not on isolation or additional precautions. 3. Observation on 3/8/26 at 3:24 p.m. of resident 84 in his room revealed he had a right abdominal drainage bag under his shirt with red drainage in the bag. There were no PPE supplies in his room or signage posted that would alert staff or visitors that he was on EBP. 4. Review of resident 84's electronic medical record (EMR) revealed he was admitted to the facility on 2/26/26. His 3/3/26 Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated he was cognitively intact. His primary admitting diagnosis was peritoneal abscess (localized collection of pus/infection within the abdominal cavity). He had a 2/27/26 physician's order to cleanse the right abdomen tube site daily with saline and cover with gauze and tape. His 2/26/26 nursing admission UDA was marked as having a right upper quadrant (RUQ) 16 French drain in section V. 5. Observation on 3/9/26 at 8:22 a.m. of resident 84's room and outside his room revealed the drainage bag was present on his right abdominal area. There was no PPE available for the staff to use. No EBP signage was posted. 6. Observation on 3/9/26 at 3:01 p.m. of resident 84's room revealed signage was posted and PPE supplies were hanging on his door for staff to use. 7. Interview on 3/10/26 at 10:44 a.m. with certified nursing assistant (CNA) S revealed she had worked for provider for ten years. Resident 84 had the drainage bag when he was admitted to the facility on 2/26/26. She agreed resident 84 had no PPE in his room before 3/9/26. She stated there was PPE available in the room next door. She used the Kardex (a report of the resident's care needs and interventions) to know how to care for residents. She noted the Kardex dated 3/6/26 did not state resident 84 required EBP to be used when she looked, but stated he had a drain to his right side of abdomen.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA HURON	1345 MICHIGAN AVENUE SW , HURON, South Dakota, 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 68 8. Interview on 3/10/26 at 10:50 a.m. with licensed practical nurse (LPN) AA revealed CNA's referred to the resident information from the Kardex to know how to care for the residents. Resident 84's information on the Kardex was last updated on 3/6/26, and he required EBP. 9. Interview on 3/10/26 at 11:39 a.m. with LPN L revealed she was responsible for placing all PPE supplies in resident rooms who were on EBP. She knew resident 84 was admitted to the facility on 2/26/26. She was not aware resident 84 needed to be on EBP until 3/9/26 around 9:00 a.m. She had placed the PPE on his door after that. She would usually go through the residents' orders to determine if that resident needed to be on EBP and would place the PPE supplies to be available to use. 10. Interview on 3/10/26 at 11:53 a.m. with registered nurse (RN) supervisor O and X revealed they assumed that resident 84 would need EBP because the resident had an abdominal drain. They would notify LPN L of the need for EBP signage and PPE supplies to be placed in the resident's room to be available for use. They were responsible for updating the resident's Kardex's and would add a resident's need to be on EBP in the Kardex. They added that resident 84 needed to be on EBP to the resident's Kardex on 2/27/26. 11. Interview on 3/11/26 at 9:22 a.m. with RN H revealed she worked the overnight shift from 7:00 p.m. to 7:00 a.m. She had access to PPE items to place to be available for use for a newly admitted resident if she noticed the resident needed to be on EBP and did not have a supply of PPE available for use. She was not aware that resident 84 had an abdominal drainage device. She was aware that PPE was not placed on resident 84's door until 3/9/26. 12. Interview and record review on 3/11/26 at 10:45 a.m. with RN/Minimum Data Set (MDS) coordinator C revealed she confirmed resident 84 admitted on 2/26/26 with an abdominal drainage device. Resident 84's 2/26/26 admission user-defined assessment (UDA) (tailored data collection for nursing in long term care) did not indicate the resident needed to be on EBP. She would expect EBP to be started upon admission for a resident who had a catheter, indwelling device, and wound care orders. She agreed EBP had not been started for resident 84 until 3/9/26.	F0880		

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F0880 SS = D	Continued from page 69 13. Interview on 3/11/26 at 11:30 a.m. with director of nursing (DON) B revealed she was the facility's infection preventionist (IP). RN supervisors O and X were to add if a resident was on EBP to the resident's Kardex. LPN L was responsible for placing EBP signage and PPE supplies in residents' rooms when a resident was on EBP. She expected that EBP would be added to a resident's Kardex if that resident required EBP and that PPE supplies would be placed in the resident's room to be available for staff to use. 14. Review of the provider's revised 5/15/25 Enhanced Barrier Precautions policy revealed "Enhanced Barrier Precautions (EBP) should be used for all residents with wounds or indwelling devices. And/or for residents with a novel or targeted MDRO [Multi Drug Resistant Organism} when they are infected or colonized with one of these organisms, and Contact Precautions do not apply. Also for those residents that have risk factors for MDRO acquisition (e.g., immunocompromised etc.)." 15. Observation on 3/10/26 at 3:50 p.m. of certified nursing assistant (CNA) EE providing catheter care for resident 20 revealed she washed her hands, put on a gown, and a pair of gloves. She placed washcloths in the residents' sink and got them wet with warm water. She used a washcloth from that sink to clean the left and right sides of the resident's abdominal folds. With those same gloved hands, she put soap on the rest of the washcloths in the sink, used one of those washcloths to clean the resident's left perineal area (genital area), and used the other side of that washcloth to clean the right side of the resident's perineal area. She used a towel to dry the resident's groin folds and the perineal area. With those same gloved hands and the last washcloth from the sink, she wiped the catheter tubing, starting from approximately four inches away from the urethral meatus (external opening to the urethra [that carries urine from the bladder out of the body)] down the catheter tubing, away from the resident. After cleaning the first few inches of that tubing, she used those same gloved hands and grasped the area of the tubing she had just cleaned and wiped the rest of the tubing downward away from the resident, with the same washcloth. With those same gloved hands, she wet another washcloth and cleaned under the resident's right breast, which was red with open areas. CNA EE said she made a mistake, and she should have changed her gloves before cleaning under the resident's breast. CNA EE then took off her gown	F0880		

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F0880 SS = D	Continued from page 70 and gloves and washed her hands in the resident's sink and then left the room. 16. Observation on 3/10/26 at 4:22 p.m. of LPN W applying powder on resident 20's open and reddened skin areas revealed she washed her hands, put on a gown, and gloves. She obtained a towel, wet it, and applied soap on it. She cleaned and dried the resident's left and right abdominal folds. She removed her gloves. Without performing hand hygiene, she put on a new pair of gloves. She applied antifungal powder under the resident's right breast and then to her left and right abdominal folds. She removed her gown, gloves, and washed her hands in the resident's sink. 17. Interview on 3/10/26 at 4:34 p.m. with LPN W and CNA EE revealed LPN W stated she should have washed her hands after removing her unclean gloves and before putting on a new pair of gloves. CNA EE agreed that after cleaning the tubing near the insertion site, she should not have touched that tubing with her contaminated gloves. CNA EE verified she was to wash her hands and apply new gloves before performing catheter care. CNA EE stated they had a refresher class about how to perform catheter care yearly, which was scheduled to be held on 3/11/26. 18. Interview on 3/12/26 at 10:25 a.m. with DON B revealed she expected the CNAs to perform hand hygiene before completing catheter care. She expected the CNAs to use washcloths and towels from the towel bar and not place them in the resident's sink. She expected the staff to remove unclean gloves and perform hand hygiene before putting on a clean pair of gloves to apply powder. 19. Review of resident 20's medical record revealed she was admitted to the facility on 2/4/26. She had physician's orders for Miconazole powder (antifungal powder) on 3/5/26, and for a Foley catheter on 3/23/26. She had physician orders from 3/6/26 through 3/9/26 for Ertapenem Sodium (antibiotic) 1 gram intravenously (IV) daily for a urinary tract infection. Her 3/9/26 care plan indicated that, she was on IV antibiotics for a UTI, required EBP due to having a Foley catheter, and was to have catheter care performed every shift and as needed.	F0880		

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F0880 SS = D	Continued from page 71 20. Review of the provider's 5/15/25 Hand Hygiene policy revealed "This facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall be initially trained as part of their orientation and regularly educated on the importance of hand hygiene in preventing the transmission of healthcare-associated infections (HAIs). All personnel shall follow the hand hygiene procedures to help prevent the spread of infections. Staff were to perform hand hygiene before putting gloves on, after taking them off, and when moving from a dirty body site to a clean body site." 21. Review of the provider's 1/14/26 Urinary Catheter/Catheter Care/Catheter Associated Urinary Tract Infections (CAUTI) Prevention Policy revealed "When a urinary catheter is in place we also need to adhere to the following procedure to assist in the prevention of catheter-associated urinary tract infections. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag."	F0880		

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K0000	INITIAL COMMENTS A recertification survey was conducted on 3/9/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Huron 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 and K363 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0222 SS = D	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 is	K0222	A delayed egress mechanism has been ordered and will be installed on the "exit" door leading to E Wing from Independence Dining Room by 4/14/2026. The maintenance director will be responsible for overall compliance. The administrator/designee will conduct audits weekly for 4 weeks and monthly for 2 months to ensure this door operates properly once the egress mechanism has been installed. The administrator/designee will report audit findings at monthly QAPI meetings on the effectiveness of the correction plan, for recommendations to adjust the correction plan, reduce the frequency of the audits, or discontinue the audits based on the audit findings.	4/14/2026

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laurie L. Solem	Administrator	04/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435020	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/09/2026

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K0222 SS = D	Continued from page 1 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 (independence dining room). Findings include: 1. Observation and testing beginning on 3/9/26 at 2:48 p.m. revealed a door marked "exit" leading from the independence dining room into the E Wing. That door was locked with an electromagnet. Testing of that door revealed it would not open or enter a delayed-egress state when pushed on in the direction of egress. That door was part of the exit access path and had to be passed through to exit the building in that	K0222		

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K0222 SS = D	Continued from page 2 location. Interview at the time of the observation with the maintenance director confirmed those conditions. He stated he was aware that door was magnetically locked, but he did not realize that door required a delayed egress. Failure to provide egress doors as required increases the risk of death or injury due to fire. That deficiency had the potential to affect 100% of the occupants of that smoke compartment. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)	K0222		
K0363 SS = E Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K0363	1.) Maintenance staff reconfigured the door jamb on the employee breakroom door on 3/9/2026. The door now closes properly and the gap is closed between the door and the jamb. 2.) A new door handle and strike latch were installed on the door to resident room 101, on 3/9/2026. The door now latches properly. 3.) The door closure on the C Wing housekeeping door was removed and a sign was placed on the door stating - "This Door Must Be Kept Closed at All Times". The breakroom door, the door latching mechanism for room 101, and the C Wing housekeeping room door, will all be audited weekly for 4 weeks, then monthly for 2 months to ensure each area is working properly. The maintenance director will be responsible for overall compliance. The administrator/ designee will conduct the audits. The administrator/designee will report audit findings at monthly QAPI meetings for discussion on the effectiveness of the correction plan, for recommendations to adjust the correction plan, reduce the frequency of the audits, or discontinue the audits based on the audit findings.	04/14/2026

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K0363 SS = E Bldg. 01	Continued from page 3 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to maintain the smoke resistive design for three randomly observed corridor doors (employee break room door, resident room 101's door, and the D-wing housekeeping door) as required. Findings include: 1. Observation and testing beginning on 3/9/26 at 11:46 a.m. revealed the door from the employee breakroom to the exit corridor had a one-half inch gap along the latch side of the top of the door frame when closed. That door did not meet the requirements for corridor doors to resist the passage of smoke with the half-inch gap at the top. Interview with the maintenance director at the same time as the observation and testing confirmed those conditions. He stated he was not aware that door did not meet the requirements for resisting the passage of smoke. 2. Observation and testing beginning on 3/9/26 at 12:36 p.m. revealed the door from resident room 101 to the exit corridor did not have a door latch and would not latch into the doorframe. That door did not meet the requirements for corridor doors to resist the passage of smoke without latching into the frame. Interview with the maintenance director at the same time as the observation and testing confirmed those conditions. He stated he was not aware that door was not latching, He further stated that room was unoccupied for quite some time and the door normally remained open. 3. Observation and testing beginning on 3/9/26 at 2:18 p.m. revealed the door to the room marked "housekeeping" in the C wing was equipped with an automatic door closer and did not latch into the frame under the power of the closer. At that same time the closer was observed as being used in a manner to hold	K0363		

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K0363 SS = E Bldg. 01	Continued from page 4 that door in the completely open position. That room was being used for holding a soiled linen cart during the survey and had a sign on the door stating it must remain closed. Doors with closers need to latch into the doorframe automatically to meet the requirements for corridor doors resisting the passage of smoke. Interview with the maintenance director at the same time as the observation and testing confirmed those conditions. He stated he was not aware that door was being held open and was not latching under the power of the automatic door closer.	K0363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. BUILDING B. WING	03/09/2026

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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 3/9/26. Avantara Huron 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
Laurie L Solem	Administrator	04/07/2026

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
	10633	A. BUILDING: _____ B. WING _____	03/12/2026

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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 from 3/8/26 through 3/12/26. Avantara Huron was found in compliance.	S 000		

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

Laurie L Solem | Administrator | 04/07/2026