STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A139	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR , FLANDREAU, South Dakota, 57028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 9/30/25. The area surveyed was potential resident neglect and accident hazards related to a resident falling out of a wheelchair resulting in a hip fracture. Flandreau Santee Sioux Tribe Care Center was found not in compliance with the following requirement: F689.	F0000	Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Executive Director/Administrator or any employees, agents or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of survey as condition of participate in Title 18 and Title 19 programs. This plan of correction is submitted as the facility's credible allegation of compliance.	10/25/2025
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on review of the South Dakota Department of Health (SD DOH) complaint intake report review, interview, security video review, record review, and policy review, the provider failed to ensure one of one certified nursing assistant (D) safely transported one of one sampled resident (1) in her wheelchair who fell out of her wheelchair and fractured her hip. Findings include: 1. Review of the 9/10/25 SD DOH complaint intake report revealed the provider and Adult Protective Services (APS) reported resident 1 fell from her wheelchair to the SD DOH. The SD DOH facility-reported incident (FRI), received on 8/30/25, indicated that on 8/29/25 at around 8:00 p.m., while certified nursing assistant (CNA) D was	F0689		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	10/22/25

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F0689 SS = G	Continued from page 1 transporting two residents in their wheelchairs, resident 1's wheelchair brake caught on the activity room window frame. She fell out of her wheelchair and complained of pain in her right hip and right foot. Resident 1 was transported to the emergency department where it was confirmed that she fractured her right hip. The provider "re-educated staff in regards to proper movement with wheelchairs." The APS report, received on 9/8/25, revealed that on 8/29/25, CNA D was transporting resident 1 and another resident in their wheelchairs to the designated smoking area. Resident 1 was "ran into the wall" which resulted in resident 1's right hip fracture. Four people lifted resident 1 up from the floor and "threw" her onto the gurney to be transported to the emergency department. Resident 1 had "emergency surgery" on 8/30/25 to correct the hip fracture. 2. Interview on 9/30/25 at 9:12 a.m. with resident 1 revealed that on 8/28/25, CNA D was pushing her and another resident at the same time out to the smoking area. Resident 1 felt that CNA D was not paying attention to where he was pushing her. Her wheelchair got too close to the wall of windows, and something caught on the window frame. She fell out of her wheelchair and "as soon as I [resident 1] hit that wall, I felt my hip pop." Resident 1 said that CNA D attempted to pick her up from the floor, but she told him that she was in too much pain. She said that she was "hollering." Once other staff arrived, they tried to pick her up off the floor to sit her in her wheelchair, but she was in too much pain to move. The ambulance was called. Two ambulance staff and two CNAs helped lift her onto the ambulance gurney. While at the hospital, it was confirmed that she had fractured her right hip. She had corrective surgery and was readmitted back to the nursing home. She explained that she had rheumatoid arthritis, a disease that affected her joints and caused contractures (permanent tightening of muscles or joints) in her hands and knees. The fall and hip fracture were painful, and she continued to experience pain in her hip after she returned to the nursing home. Since returning to the nursing home, she felt increased anxiety and wanted to talk with someone about her side of the story. She became tearful as she felt that no one wanted to talk to her about the accident. She confirmed she continued to go out to smoke every day.	F0689	Free of Accident Hazards/Supervision/ Devices 1. Corrective Action for Residents Found to Have Been Affected R1 continues to reside in the facility. The Director of Nursing and/or designee completed Morse Fall Scale assessment and a manual wheel chair use assessment on R1. R1 was offered therapy services on September 30, 2025 and an order was obtained. The Director of Nursing and/or designee made revisions to R1s' care plan as needed to reflect all safety interventions. The Director of Nursing and/or designee will ensure that R1s revised assessments and care plans are in the electronic medical record system for staff involved in the care of each resident to review and reference. 2. Corrective Action for Residents Having the Potential to Be Affected All residents who reside in the facility that use wheelchairs are at risk for a fall. The Director of Nursing and/or designee completed Morse Fall Scale assessment on all residents and a manual wheel chair and/or electric wheel chair use assessment on all residents based on their need for a wheel chair. The Director of Nursing and/or designee will make revisions to all care plan as needed to reflect all safety interventions. The Director of Nursing and/or designee will ensure that all revised assessments and care plans are in the electronic medical record system for staff involved in the care of each resident to review and reference.	

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F0689 SS = G	Continued from page 2 She had to close her eyes and tensed up as she was transported past the area where she fell, as she was fearful of falling again. She confirmed that CNA D still worked at the facility. She did not fear him. She did not feel like he did it on purpose and that it was an accident. She indicated that she was okay with CNA D continuing to help care for her. 3. Interviews with a random sample of residents throughout the facility confirmed no other concerns with staff providing their care. 4. Interview on 9/30/25 at 11:00 a.m. with licensed practical nurse (LPN) E revealed that she was a contracted travel nurse and had not heard about the above accident. She could not recall receiving any recent education about safe resident transporting expectations. She did not know where to find the provider's policy on what to do in the event of a resident fall, but she was able to verbalize understanding of the proper nursing procedures following a resident fall. When she started her contract at that facility, she received a week of mentored training to learn the normal facility routines and procedures. 5. Interview on 9/30/25 at 11:16 a.m. with CNA F and CNA K revealed that neither of them had been at the facility when the above accident happened, but they heard about it when they came back to work. They both confirmed that they did not receive any follow-up education about the fall policy or safe resident transporting expectations. CNA F indicated the report she received about the accident was "more of an FYI [for your information]." Continued interview on 9/30/25 at 11:20 a.m. with CNA F individually revealed she heard that CNA D was pushing two residents in their wheelchairs at the same time. She indicated that was not the proper procedure and it was safer to push one resident at a time in a wheelchair. CNA F confirmed she knew where to find the facility policies and procedures regarding falls, accidents, and other topics. She was able to point out where the policies were located. 6. Interview on 9/30/25 at 11:39 a.m. with certified	F0689	3. Systemic Changes to Prevent Recurrence The Director of Nursing and/or designee will educate all staff members on pushing, moving and turning a wheelchair guidelines to include : Ask patient to place feet on wheelchair footrests and hands on wheelchair armrests or lap. Do not push a wheel chair without patient's feet on the foot rest and only push one (1) patient in a wheel chair at one time. Do not pull a wheel chair. The Director of Nursing and/or designee will educate all staff members on accidents and supervision policy, fall prevention program policy, F-689 Plan of Correction, and Practice Guideline: Accidents and Supervision "All staff can accompany residents in wheelchairs. All staff members will be consistent in resident transport and will not handle two residents in wheelchairs simultaneously as this can lead to an adverse event" training. For those staff members that are not able to be provided education verbally and in writing the education will be mailed to them via registered mail. 4. Monitoring to Ensure Ongoing Compliance The Director of Nursing and/or designee will review each incident report upon occurrence to ensure appropriate interventions are implemented and updated plan of care is complete. The Director of Nursing and/or designee will complete random observations of staff transporting resident across all shifts to ensure proper and safe resident handling/transporting practices three times per week for six weeks. Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Council for comment and suggestions.	

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F0689 SS = G	Continued from page 3 medication aide (CMA) G and CNA H revealed that neither of them was at the facility when the above accident occurred. They did not receive a briefing or report about the accident when they returned to work. They were not provided education recently about safe resident transportation. They learned about that accident from resident 1 when she returned from the hospital. 7. Review of the security camera footage on 9/30/25 at 12:17 p.m. with interim administrator A revealed that the accident occurred on 8/28/25 at around 7:25 p.m. CNA D was pushing two residents in their wheelchairs at the same time. He was pushing resident 1 with his right hand, and resident 2 with his left hand. Resident 1 was close to the wall of windows of the activity room, and it appeared that something on her wheelchair caught on the window as the wheelchair suddenly stopped, and resident 1 fell forward out of her wheelchair and landed on her right hip. CNA D attempted to catch her, but he did not make it to her in time. Several other staff attended to the scene immediately and registered nurse (RN) J began measuring resident 1's vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate). CNA D and another CNA brought the full body lift (a mechanical lift and sling used to lift a person's full body) near resident 1 and attempted to slide the lift sling underneath the resident. They were not able to as resident 1 was showing signs of pain. LPN I sat on the ground with resident 1 and waited with her for the emergency medical service (EMS) to arrive. Two EMS employees, CNA D, and LPN I helped to lift resident 1 from the ground onto the gurney. Resident 1 left the facility with the two EMS employees via ambulance. 8. Review of the provider's incident investigation documentation revealed that they interviewed all staff and all interviewable residents. Staff questions included "Has anyone reported to you that they do not feel safe in the facility? Yes or No," "Has anyone reported to you that they do not feel safe with their care team? Yes or No," "Has any resident reported abuse, neglect, theft, mistreatment to you? Yes or No," and "Who do you report abuse, neglect, theft, or mistreatment to?" Resident interview questions included "Do you feel safe	F0689		

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F0689 SS = G	Continued from page 4 in the facility? Yes or No. [If] no, why?" "Do you feel safe with your care team? Yes or No. [If] no, why?" "In the past week has anyone physically abused you? Yes or No," and "In the past week has anyone mistreated you? Yes or No." Resident 1 was interviewed on 9/4/25 and answered "Yes" to the first and second resident questions regarding feeling safe, and "No" to the third and fourth resident questions regarding physical abuse and mistreatment. The investigation documentation included the SD DOH FRI, a letter to the SD DOH from administrator A that explained the provider's investigation process and included RN J and CNA D's witness statements, and CNA D's background check and training records from his contract staffing agency. The letter from administrator A to the SD DOH included the statement, "In good faith effort the facility will provide education on how to push a wheelchair." There was no documentation provided to support who was educated, what the education topics included, or when the education occurred. 9. Review of resident 1's electronic medical record revealed that she was admitted on 6/17/25. Her 6/23/25 Brief Interview for Mental Status score from her admission Minimum Data Set (MDS) assessment was 14, which indicated her cognition was intact. She had a diagnosis of rheumatoid arthritis, which is a disease where the body's immune system mistakenly attacks the joints, causing pain, swelling, and stiffness in the joints. She had contractures in her knees and hands, and she could not bend or move her joints normally. Her current care plan indicated "Locomotion: Her primary mode of transportation is via manual wheelchair. She is dependent on staff [assistance] of 1. D/T [Due to] her contracture she does refuse to utilize her foot pedals. Continually remind her to utilize the foot pedals. Foot pedals need to be on [when] going to appointments." That was initiated on 7/7/25 and revised on 9/26/25. A progress note from 8/29/25 read, "Resident had a witnessed fall at 1925 [7:25 p.m.], after contacting Avel E-care for transport due to resident complaint of 10/10 right hip and right foot pain. Resident transported out of facility via Moody County ambulance to [provider name] ED [emergency department] per resident request at approximately 2005 [8:05 p.m.] this evening. This RN contacted [provider name] ED for [a]	F0689		

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F0689 SS = G	Continued from page 5 nurse-to-nurse report." Resident 1's primary care physician was contacted with the update. A progress note from 8/30/25 read, "This RN received an update from [provider name] ED from Nurse [name redacted], resident is being admitted and results from the x-ray to the right hip show a fracture, currently waiting for results of the x-ray to right leg. Faxed MAR [medication administration record] to [provider name] Pharmacy. Resident gave this RN a verbal okay to sign bed hold and verbalized understanding of bed hold policy." Resident 1 returned to the facility on 9/3/25 after surgical repair of her hip. She returned with the following pain relief medication prescriptions: *Lidocaine patch (a pain relief patch applied to the skin). To be applied to the affected area and remain on for 12 hours, then taken off for 12 hours. That was to repeat for three days. Started on 9/13/25 and discontinued after 9/15/25. *Diclofenac (a pain relief medication) tablet, 75 mg (milligram). Give one tablet by mouth twice daily as needed. Started on 6/18/25. From 9/3/25 to 9/20/25, she used that medication 19 times. *Hydrocodone 5 mg (an opioid)/acetaminophen 325 mg (an analgesic pain relief medication) combination tablet. Give 1 tablet by mouth every eight hours as needed for pain. Started on 9/8/25. From 9/8/25 to 9/30/25, she had used that medication 43 times. *Hydromorphone 2 mg (an opioid) tablet. Give one tablet by mouth every four hours as needed for pain for up to five days. Started on 9/3/25 and discontinued on 9/8/25. During that time, she used that medication 18 times. 10. Phone interview on 9/30/25 at 3:01 p.m. with CNA D revealed that on 8/29/25 at around 7:25 p.m., he was taking two residents out to the smoking area. He was pushing residents 1 and 2 at the same time. Resident 1 was on his right side, and resident 2 was on his left side. As they were passing by the round activity room, part of resident 1's wheelchair caught on the wall of windows and "she began to fall out of her wheelchair. I went to grab her to lower her to the floor." He called for help over the walkie talkies. Two other CNAs and two nurses responded to help. He indicated that he felt that they were "short-handed"	F0689		

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F0689 SS = G	Continued from page 6 that evening as he felt rushed to get his four residents out to their last smoke break for the day. One of the residents was feeling anxious to go outside, so he transported two residents at one time. He confirmed that he knew the general rule was to transport one resident at a time in their wheelchairs. After the incident, the nurse asked him to write down his statement. No one else interviewed him about the incident. He confirmed there was no disciplinary action, and there was no follow-up education provided. He was reassigned to the other unit for about a week or two after the incident but had since been reassigned back to resident 1's unit. He confirmed that when resident 1 returned to the facility, he went to apologize to her and said, "I was at a loss for words." 11. Phone interview on 9/30/25 at 3:16 p.m. with LPN I revealed that he was resident 1's nurse that evening shift on 8/29/25. He did not witness the incident. He was preparing for the evening medication pass when CNA D was pushing residents 1 and 2 out to the smoking area. He said that "I was not comfortable with him [CNA D] pushing two residents at the same time." He said that he expected staff push one resident at a time in their wheelchairs. He heard the commotion as "she [resident 1] was in excruciating pain. She was yelling out in pain." He and another staff attempted to roll the full body lift sling underneath her to pick her up, but resident 1 was in too much pain to roll her on her side. They decided to leave her lying on her back until the EMS employees arrived. He confirmed that no one interviewed him about his involvement in the incident and that there was no follow-up education provided about resident safety protocols or policies. 12. Phone interview on 9/30/25 at 3:29 p.m. with CNA L revealed that she witnessed part of the incident. She was filling in for the front desk representative that day and she was delivering residents' packages. She saw CNA D pushing two residents at one time towards the smoking area. She confirmed that resident 1's wheelchair was close to the wall of windows. After resident 1 fell out of her wheelchair, she took charge of the other residents in the area and brought them to a safe location to give everyone else more room.	F0689		

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F0689 SS = G	Continued from page 7 She confirmed that no one had interviewed her about what she saw or her involvement in the incident, and there had been no follow-up education provided about resident safety. She said that she was a newer CNA and that some staff members told her it was okay to transport two residents at once, and others said that was not okay to do. 13. The survey team attempted to contact RN J on 9/30/25 at 3:38 p.m. via phone and left a voicemail. 14. Interview on 9/30/25 at 4:34 p.m. with interim administrator A and MDS coordinator B revealed that it was both their expectations that staff should push one wheelchair at a time. MDS coordinator B confirmed she was the interim director of nursing. They said that "everyone should have foot pedals." Interim administrator A said that since she started a couple of months ago, she had noticed a lack of wheelchair foot pedals and was in the process of obtaining more. They both confirmed that resident 1 did not like the normal wheelchair foot pedals due to the contractures in her knees. With the way resident 1's legs were positioned, the standard wheelchair foot pedals were too far forward for her comfort. Their investigation included gathering a statement from CNA D and resident 1 about what had happened. MDS coordinator B confirmed that RN J spoke with CNA D and educated him on pushing one resident at a time in their wheelchair. 15. RN J returned the survey team's phone call on 9/30/25 at 6:08 p.m. That interview revealed that she was working on the "green wing," and she was preparing to administer resident medications. She heard someone yelling, "My hip! My hip!" She went out of the "green wing" and saw resident 1 on the floor. CNA D told her that resident 1's wheelchair brake got caught on the side of the window panels. She measured the resident's vitals. Resident 1 was experiencing "10 out of 10 pain." They were attempting to use the full body lift to lift her up off the floor, but resident 1 was not able to tolerate that movement due to the pain. She contacted the on-call emergency medical provider, and they ordered for resident 1 to be assessed that the ED.	F0689		

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F0689 SS = G	Continued from page 8 She reported the incident to administrator A and the director of nursing. She instructed CNA D to write out a witness statement. She did not obtain witness statements from anyone else. She said that it was her expectation that staff transport one resident at a time in their wheelchairs. She confirmed that she provided education to CNA D to utilize the walkie talkies to ask for help, and to transport one resident at a time rather than two at a time. 16. Review of the provider's 1/22/23 FALLS-CLINICAL PROTOCOL policy revealed: *"...3. Documentation -Responsible Parties: --Nursing staff --Physicians (if required) *3.1. Incident Documentation -Fall Report: Document the details of the fall, including: --Date, time, and location of the fall. --Circumstances leading to the fall... --Observations of the resident's condition immediately after the fall. --Any witnessed reports or bystanders. --Interventions provided immediately after the fall..." *"...5. Post-Fall Evaluation and Prevention -Responsible Parties: -Nursing staff -Social Worker or Care Coordinator -Physical Therapists (if applicable) -Physician (if applicable) *5.1. Reassess Fall Risk	F0689		

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F0689 SS = G	Continued from page 9 -...Update Care Plan: Adjust the care plan to address fall prevention strategies, such as: --Increased supervision or assistance with mobility... *5.2. Family and Resident Education -Family and Resident Discussion: Educate the resident and their family about the fall and the potential consequences. Discuss preventative measures that can be implemented moving forward. -Environmental Modifications: Ensure the resident's environment is safe (e.g., removing tripping hazards, ensuring good lighting, and using non-slip rugs)." *The policy did not include staff education to prevent falls.	F0689		