STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A140	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUSTER CARE AND REHAB CENTER	1065 MONTGOMERY ST , CUSTER, South Dakota, 57730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An onsite revisit survey was conducted on 10/23/25 for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities for all previous deficiencies cited on 8/26/25. Custer Care and Rehab Center was found not in compliance with the following requirements: F637, F644, F700, and F727.	F0000		
F0637 SS = E	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on plan of correction (POC) with a completion date of 10/10/25 for the 8/26/25 recertification survey review, record review, and interview, the provider failed to ensure the POC was followed for two of two sampled residents (6 and 7) who experienced two or more areas of decline from their baseline conditions, had a significant change in status assessments completed related to fractures that resulted from their falls. Findings include: 1. Review of the provider's 10/7/25 signed POC with a completion date of 10/10/25 revealed: *Resident 6 had been identified during the 8/26/25 survey to have experienced significant changes in her condition after a fall on (date).	F0637	Non-compliance for residents 6 and 7 will be corrected by new MDS. Resident 6 significant change ARD 10/27/2025. Resident 7 will be noted on quarterly MDS with ARD date of 11/17/2025. Regulation printed and reviewed with MDS, DON and SSD by administrator. DON and MDS Coordinator re-edicated on significant change policy by administrator. DON and MDS coordinator enrolled in RAC Course through AAPACN for continuing education and assurance of compliance. Daily IDT stand up meeting minutes updated to reflect discussion of ongoing or watch list residents for significant changes. This will remain in place as part of IDT meeting permanently. MDS Coordinator will report to QAPI the number of residents who had a significant change completed. This will remain in place as part of QAPI permanently.	11/15/2025

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
Madison L. Barta	Administrator	11/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A140	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/23/2025

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F0637 SS = E	Continued from page 1 *Resident 7 had been identified during the 8/26/25 survey to have experienced significant changes in her condition after a fall on (date). *Neither resident 6 nor 7 had a significant change assessment completed following those falls. *The POC indicated "MDS coordinator or designee will completedsig [completed significant] changes [assessments] for residents 6 and 7 by 10/10/25." 2. Interview on 10/23/25 at 1:57 p.m. with Minimum Data Set (MDS) nurse/assistant director of nursing (ADON) E revealed: *She had not completed a significant change assessment for residents 6 and 7 after the 8/26/25 survey. -She planned to complete them with the residents' next MDS assessments that were due in November 2025. *She was not aware that the POC indicated the significant change assessments for residents 6 and 7 were to be completed by 10/10/25. 3. Interview on 10/23/25 at 3:30 p.m. with administrator A revealed: *MDS nurse/ADON E was responsible for completing residents' significant change assessments. *MDS nurse/ADON E had no training on how to complete significant change assessments. -MDS nurse/ADON E planned to attend MDS training in December 2025. -When MDS nurse/ADON E had MDS related questions, she contacted the nurse consultant at the South Dakota Department of Human Services, Long Term Services and Support. *Administrator A was not present when the POC was developed and did not participate in its development. -She returned to work on 10/20/25, was familiar with the POC, and had "started auditing." *Administrator A acknowledged that the POC was not followed, and the significant change assessments were not completed for resident 6 and 7.	F0637		
F0644 SS = D	Coordination of PASARR and Assessments	F0644		11/15/2025

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F0644 SS = D	Continued from page 2 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 plan of correction (POC) with a completion date of 10/10/25 for the 8/26/25 recertification survey review, record review, and interview, the provider failed to ensure the POC was followed one of one sampled resident (6) had a Level II Preadmission Screening and Resident Review (PASRR) screening (a federally mandated program tht requires all individuals applying for admission to or currently residing in a Medicaid-certified nursing facility to be screened to determine if they have a serious mental illness, intellectual disability, or developmental disability. Level I screening is conducted to identify if an individual has a PASRR condition; if positive, a comprehensive Level II evaluation is performed to determine individual needs, appropriate placement, and services) completed. Findings include: 1.Review of the provider's 10/7/25 signed POC with a completion date of 10/10/25 revealed: *Resident 6 had been identified during the 8/26/25 survey to have no Level II PASRR completed. *The POC indicated "PASRR completed for resident 6."	F0644	To correct non-compliance, Resident Review PASRR form submitted 10/23/2025. Results letter states Negative Level I. Risk committee minutes updated to include new mental health diagnosis and Level II PASRRS to weekly meeting. SSD will report to QAPI monthly the number of new PASRR relevant diagnosis's and PASSRS completed monthly for three months or until substantial compliance has been determined. Regulation printed and reviewed with MDS, SSD, and DON by administrator	

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F0644 SS = D	Continued from page 3 2. Interview and review of the provider's 10/7/25 signed POC with a completion date of 10/10/25 on 10/23/25 at 1:05 p.m. with social service director (SSD) F regarding a Level II PASRR for resident 6 revealed: *She was not aware that the POC for the 8/26/25 survey indicated a LEVEL II PASRR would be completed for resident 6. *She was responsible for ensuring the required Level II PASRRs were completed for residents. 3. Interview on 10/23/25 at 3:31 p.m. with administrator A regarding the provider's PASRR process revealed: *SSD F was responsible for ensuring the required Level II PASRRs were completed. *She thought SSD F had misunderstood when a Level II PASRR was required, including that is was required when a resident had a new mental health diagnosis. *Administrator A was not present when the POC was developed and did not participate in its development. -She returned to work on 10/20/25, was familiar with the POC, and had "started auditing." *Administrator A acknowledged that the POC was not followed, and that a Level II PASRR was not completed for resident 6.	F0644		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.	F0700	Regulation printed and reviewed with MDS and DON by administrator. Assessments on residents affected completed. Re-assessments will be completed on all residents using devices with each MDS and discussed at care conferences where consents will be renewed. Risk committee minutes updated to reflect all residents using devices will be discussed weekly at risk meeting. Maintenance or designee will check bedrail installation and function weekly as part of PM program. PM completion will be reported monthly to the QAPI committee to ensure continued safety compliance.	11/15/2025

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F0700 SS = D	Continued from page 4 §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on plan of correction (POC) with a completion date of 10/10/25 for the 8/26/25 recertification survey review, record review, and interview, the provider failed to ensure the POC was followed for three of three sampled residents (3, 5, and 8) who used side rails attached to the bed and did not have other attempted interventions documented. Findings include: 1. Review of the provider's 10/7/25 signed POC with a completion date of 10/10/25 revealed: *Residents 3, 5, and 8 had been identified during the 8/26/25 survey to have bed rails on their beds with no documentation of interventions tried prior to their use. *The POC indicated "Resident 3, 5, and 8 [will be] assessed by MDS coordinator or designee for proper interventions tried prior to use of side rail". 2. Interview on 10/23/25 at 2:11 p.m. with Minimum Data Set (MDS)/assistant director of nursing (ADON) E regarding side rail assessments for interventions attempted prior to the use of side rails revealed: *There was no documented assessment completed after the 8/26/25 survey for residents 3, 5, and 8 for proper interventions attempted before their use of a side rail. *She was not aware that the POC indicated those assessments would be completed by 10/10/25. 3. Interview on 10/23/25 at 3:33 p.m. with	F0700		

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F0700 SS = D	Continued from page 5 administrator A regarding assessments for interventions attempted before a resident's use of side rails revealed: *Assessments for other interventions prior to a resident's use of a side rail for newly admitted residents were completed. *She was aware that those assessments for residents 3, 5, and 8, had not been completed. *She was not present when the POC was developed and did not participate in its development. -She returned to work on 10/20/25, was familiar with the POC, and had "started auditing." *Administrator A acknowledged that the POC was not followed, and residents 3, 5, and 8 assessments for interventions attempted prior to their side rail use were completed.	F0700		
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility … must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a	F0727	Facility RN Waiver submitted and denied. Facility hired an additional part time RN for 2 days/week to provide required coverage. DON and ADON will provide coverage on any days that are not sufficiently covered by an RN. BOM will complete monthly nursing schedule and report any RN coverage needed for the upcoming schedule at QAPI meeting. This will remain a permanent part of QAPI. RN Coverage field added to nursing schedule. BOM will complete the schedule and DON will review and approve, using the RN coverage field to audit coverage and make schedule arrangements to ensure compliance. BOM will send staffing sheets before the end of each day for the upcoming day to Administrator and DON via text message for review. Saturday - Monday will be sent Friday.	11/15/2025

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F0727 SS = F	Continued from page 6 registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on plan of correction (POC) with a completion date of 10/10/25 for the 8/26/25 recertification survey review, record review, and interview, the provider failed to ensure the POC was followed for registered nurse (RN) coverage (worked for eight consecutive hours each day) on 10/12/25. Findings include: 1.Review of the provider's 10/7/25 signed POC with a completion date of 10/10/25 revealed: *"Interview and review of the provider's licensed nurse schedule from 8/1/25 through 8/24/25 on 8/26/25 at 3:14 p.m. with DON B confirmed there were three days with no RN coverage, which included 8/9/25, 8/17/25, and 8/24/25." *The POC indicated "Will ensure proper RN coverage until waiver is approved." 2. Interview on 10/23/25 at 2:13 p.m. with director of nursing (DON) B revealed: *The provider had applied for an RN waiver and was not approved or denied for that waiver on 10/12/25. *She confirmed there was no RN coverage for 8 hours on 10/12/25. 3. Interview on 10/23/25 at 2:46 p.m. with business office manager (BOM) H revealed: *She was responsible for scheduling the nursing employees' shifts to work. *There was no RN available to schedule to work on 10/12/25. -She had not scheduled an RN to work for 8 consecutive hours on 10/12/25.	F0727		

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F0727 SS = F	Continued from page 7 *The provider had requested an RN waiver, and it was not approved. 4. Interview on 10/23/25 at 3:34 p.m. with administrator A revealed: *BOM H was responsible for scheduling the RNs to work. *The RN who worked on Sundays was not available to work on 10/12/25 (Sunday). *BOM H had not notified the management staff that the RN was not available to be scheduled for 10/12/25. *Administrator A was not present when the POC was developed and did not participate in its development. *Administrator A returned to work on 10/20/25, was familiar with the POC, and had "started auditing." *Administrator A acknowledged that the POC was not followed, and that there was no RN scheduled to work 8 consecutive hours on 10/12/25.	F0727		

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	80076	A. BUILDING: _____ B. WING _____	R 10/23/2025

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{S 000}	Compliance/noncompliance Statement An onsite revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted on 10/23/25 for deficiencies cited on 8/26/25. Custer Care and Rehab Center was found not in compliance with the following requirement: S206.	{S 000}		
{S 206}	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel	{S 206}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Madison L. Barta — TITLE: Administrator — (X6) DATE: 11/10/2025

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{S 206}	Continued From page 1 education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on the plan of correction (POC) with a completion date of 10/10/25 for the 8/26/25 licensure survey review and interview, the provider failed to ensure the POC was followed for: *Four of four sampled employees (B, K, O, and P) who had not completed the required orientation training topics within 30 days of hire. *One of one sampled employee (Q) who had not completed the required annual training topics. Findings include: 1. Review of the provider's 10/8/25 signed POC with a completion date of 10/10/25 revealed the provider's planned corrective actions included: *"Ensure that employees B, K, O, and P get orientation training completed by BOM [business office manager]. *"Ensured employee Q will have annual training completed". *"Administrator or designee reviewed orientation process with BOM". Interview and POC review on 10/23/25 at 2:41 p.m. with BOM H revealed: *She confirmed B, K, O, and P's orientation training and employee Q's annual training was not completed as the provider's planned corrective action in the POC had indicated the training was to be completed by 10/10/25. *BOM H stated she believed the training requirement applied only to new employees, not existing ones. -She thought that she was only responsible for	{S 206}	To correct non-compliance, employees B, O, P and Q were provided required education by BOM. Employee K terminated employment. All staff meeting held 11/5/2025 where new orientation process and education ex[ectations for all departments was reviewed by administrator. Orientation process reviewed by Admininstrator with all department heads. New Orientation checklist developed and implemented for tracking compliance. Administrator will audit all orientation checklists monthly and report to QAPI the percentage of successful orientations completed and if/when any corrective actions were taken to ensure compliance is met monthly for six months.	11/15/25

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{S 206}	Continued From page 2 auditing education records. *BOM H confirmed she had not reviewed the orientation process with the administrator or designee as indicated in the POC. Interview on 10/23/25 at 3:12 p.m. with Administrator A revealed: *She was not present when the POC was developed and did not participate in its development. -She returned to work on 10/20/25, was familiar with the POC and had "started auditing." *Administrator A acknowledged the POC had not been followed, and employees B, K, O, P, and Q had not completed the required training.	{S 206}		