

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435070	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026
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NAME OF PROVIDER OR SUPPLIER AVERA SISTER JAMES CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 WEST 11TH STREET , YANKTON, South Dakota, 57078
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F0000	<p>INITIAL COMMENTS</p> <p>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/3/26 through 2/5/26. Areas surveyed included abuse/neglect as it related to a resident fall from the staff not using a gait belt, a resident fall involving a whirlpool chair, and a resident fall involving an electric scooter. Avera Sister James Care Center was found not in compliance with the following requirement: F689</p>	F0000		
F0689 SS = G	<p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.</p> <p>The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>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 staff used assistive safety devices for one of one resident (1) who fell, suffered a broken nose, and required emergency room treatment, while ambulating to a meal when one of one certified medication aide (E) failed to use a gait belt (a waist strap gripped as support for safe mobility and transfers) while assisting resident 1 with ambulating (walking).</p> <p>Findings include:</p> <p>1. Review of the 1/28/26 SD DOH FRI regarding resident 1 revealed:</p>	F0689	<p>Facility reviewed the current LTC Falls & Accident Policy along with the Lifting-Transferring Policy which includes the use of Gait Belts. Identified residents' transfers followed the care plan & have since been done correctly. All other residents' transfers were reviewed that they were completed according to the resident's care plan.</p> <p>Correction was completed to the staff member involved after the incident had occurred which included counseling the staff member after the fall on following resident care plan on how to transfer a resident & gait belt use. Inservices's on facility Lifting-Transfer Policy, fall & Accident Policy, Gait Belt use along with their role & responsibility for resident safety will be completed for Nurses & CNA's by the Nurse Educator by March 5, 2026. Monitoring & Audits of Lifting-Transfer process & use of Gait belts will be done by the RN Household Coordinator weekly times 4 weeks, monthly times 3 months, then quarterly times 3 quarters. RN Household Coordinator will report findings to Director of Nursing for compiling & submitting to QAPI Committee for review & recommendations monthly times 3 months, then quarterly times 3 months.</p>	3/5/2026

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 <i>Anthony L Erickson</i>	TITLE Vice President-Senior Svcs	(X6) DATE 2/24/2026
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F0689 SS = G	<p>Continued from page 1</p> <p>*He was ambulating to the dining room.</p> <p>*He tripped over his feet and fell forward hitting his head on a table and landed on the floor.</p> <p>*CMA E was walking with the resident, but did not use a gait belt.</p> <p>*He was sent to the emergency room for evaluation.</p> <p>*He had a nasal bone fracture (broken nose) and multiple skin tears on his face and arms.</p> <p>2. Observation and interview on 2/4/26 at 9:10 a.m. with resident 1 in his room revealed:</p> <p>*He had multiple cuts and bruises on his face and arms from a recent fall.</p> <p>*He used his walker to help keep his balance when he walked.</p> <p>*He stated he got ahead of himself and was going too fast when he tripped and fell on his way to the dining room.</p> <p>*A staff member was walking with him when he fell.</p> <p>3. Interview on 2/4/26 at 2:25 p.m. with CMA F revealed:</p> <p>*A gait belt was used when transferring or walking with a resident unless they were independent.</p> <p>*The therapy department would evaluate the residents to determine the level of supervision for transfers and walking.</p> <p>*Resident 1 was an assist of one (needed one staff member to assist him with walking) according to his care plan (personalized plan that addresses a resident's care needs, goals, and interventions) so he would use a gait belt when walking with him.</p> <p>4. Interview on 2/4/26 at 2:35 p.m. with CMA E revealed:</p> <p>*She was walking with resident 1 to the dining room when he fell.</p> <p>*She knew he was an assist of one with ambulation.</p>	F0689		

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F0689 SS = G	<p>Continued from page 2</p> <p>*He started walking too fast and his walker was too far out in front of him.</p> <p>*She asked him to slow down.</p> <p>*She did not use a gait belt while walking with resident 1.</p> <p>*He tripped over his own feet and fell into the table and hit his head.</p> <p>*She was educated on gait belt use after that incident.</p> <p>5. Review of resident 1's electronic medical record (EMR) revealed:</p> <p>*He was admitted on 11/28/25.</p> <p>*His Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated he was cognitively intact.</p> <p>*His admitting diagnosis included congestive heart failure (CHF), weakness, and hyponatremia (low blood sodium levels).</p> <p>*His care plan indicated:</p> <p>- "I am at risk for falls due to [use of] high-risk meds, morbid obesity, impaired mobility, [and] need for assistance."</p> <p>- "I will have no falls in the next 90 days."</p> <p>- "Ensure [my] call light [is] in reach [while I am] in [my] room."</p> <p>- "Fall safety rounds (staff checking on residents on a routine basis)."</p> <p>- "Walker with gait belt [and] 1 assist."</p> <p>- "W/C [wheelchair] with foot pedals on for distance."</p> <p>- "Cue resident to slow down when ambulating"</p> <p>*His fall risk assessments completed on 12/1/25, 12/4/25, 12/21/25, 12/31/25, 1/22/26, and 1/28/26 indicated that resident 1 was at a high risk for falling.</p>	F0689		

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F0689 SS = G	<p>Continued from page 3</p> <p>6. Interview on 2/4/26 at 3:45 p.m. with physical therapist D revealed:</p> <ul style="list-style-type: none"> *She assisted resident 1 with therapy and his therapy services ended on 1/22/26. *He was discharged from therapy with instructions for contact guard assist of one with a gait belt (a staff member would walk with him, and he would have a gait belt on). *He was on a walk to dine program (staff would walk with him to and from meals). *She expected that the staff would use a gait belt when resident 1 was walking. <p>7. Interview and review of resident 1's care plan on 2/6/26 at 8:30 a.m. with registered nurse (RN) C revealed:</p> <ul style="list-style-type: none"> *She confirmed resident 1 had a walker, a gait belt, and was a one assist on his care plan. *That care plan information was transferred to the staff daily sheets (printed information with resident care needs). *She expected the staff to use a gait belt when resident 1 was ambulating. *Education was provided to the staff after his 1/28/26 falling incident. <p>8. Interview on 2/6/26 at 10:30 a.m. with administrator A and director of nursing (DON) B revealed:</p> <ul style="list-style-type: none"> *They expected staff to follow the resident's care plan. *They agreed CMA E should have used a gait belt when walking with resident 1. *Education was provided to the staff regarding gait belt use and following the care plan. *Gait belt audits were being completed. <p>Review of the provider's February 2026 SJCC [Sister James Care Center] Gait Belt- LTC [Long Term Care] policy revealed "Gait belts will be used for any</p>	F0689		

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F0689 SS = G	<p>Continued from page 4 resident who requires assistance with transfers and/or ambulation."</p> <p>Review of the provider's revised October 2024 LTC Falls and Accidents-System Standard policy revealed:</p> <p>**C. Review of individualized, resident-centered interventions, including adequate supervision and assistive devices, to reduce individual risks related to hazards in the environment must occur. The plan of care must be updated/modified accordingly."</p>	F0689		

