STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435072	A. BUILDING _____ B. WING _____	C 06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN SISTERS LIVING CENTER	1201 HWY 71 SOUTH HOT SPRINGS, SD 57747

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F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 6/26/25. Areas surveyed included medication administration, medication errors, wound care interventions, potential staff to resident abuse, and accident prevention and interventions. Seven Sisters Living Center was found not in compliance with the following requirements: F689 and found to have past non-compliance with the following requirement at F600.	F 000		
F 600 SS=D	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) facility-reported incident (FRI), record review, and interview, the provider failed to protect the resident's right to be free from verbal abuse by one of one cook (J) during the supper meal for one of one sampled resident (3). This	F 600	Past noncompliance: no plan of correction required.	

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

CEO 7.14.2025

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F 600	Continued From page 1 citation is considered past non-compliance based on a review of the corrective actions the provider implemented immediately following the incident. Findings include: 1. Review of the provider's 5/8/25 SD DOH FRI revealed: *During the supper meal on 5/8/25, resident 3 was seated at her table in the dining room using her tablet when she noticed cook J looking at her. She asked "what," and cook J responded in a tone and attitude resident 3 found inappropriate. Resident 3 expressed that she would not eat due to his attitude. *Cook J then used vulgar language and told her to starve. *Resident 3 left the dining room table and had seen certified nursing assistant (CNA) G and told her what had happened. CNA G reported it to licensed practical nurse (LPN) D. *LPN D spoke with cook J, who denied directing vulgar language specifically at resident 3 but admitted to using vulgar language. LPN D then informed the lead resident care manager (CM) B about the incident. *CM B notified the director of environmental services (EVS) C, who was cook J's supervisor and he responded by terminating cook J's employment and escorted him from the facility on 5/8/25. EVS C also apologized to resident 3 and informed her that cook J was no longer employed at the facility. *Following the incident, dietary supervisor F initiated education with all dietary staff on verbal abuse towards residents. 2. Review of resident 3's electronic medical record (EMR) revealed: *She was admitted on 4/18/22.	F 600		

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F 600	Continued From page 2 *Her Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated she was cognitively intact. 3. Interview on 6/26/25 at 11:06 a.m. with resident 3 revealed: *She reported that while she was seated at the table during supper, using her tablet, she believed her tablemates were ordering. *Upon looking up, she noticed cook J was looking at her. She asked "what" and stated that cook J responded with an inappropriate tone and attitude, she expressed she did not like his attitude, he then used vulgar language and told her to starve. *Following the incident, she left the table and informed CNA G about the incident with cook J. *She expressed to staff that she did not want to eat any food prepared by cook J. Staff went downtown and had gotten a chicken salad for her for supper. *She indicated this was not the first time cook J had used an inappropriate tone with her. 4. Interview on 6/26/25 at 1:30 p.m. with CNA G regarding the 5/8/25 FRI for resident 3 revealed: *Resident 3 had informed her of the incident with cook J right after it happened. *CNA G had offered to get resident 3 a room tray for supper that evening, but the resident declined. *Resident 3 requested CNA G not to report the incident, but CNA G knew that was verbal abuse by cook J and she needed to report the incident. *CNA G reported it to LPN D, charge nurse on duty that night. 5. Phone interview on 6/26/25 at 1:39 p.m. with LPN D regarding the 5/8/25 FRI for resident 3 revealed:	F 600		

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F 600	Continued From page 3 *He had been informed about the incident of cook J towards resident 3 by CNA G. *He initially went to visit with resident 3, but she was upset, he chose instead to speak with cook J. *Cook J admitted to using vulgar language that evening but denied directing any directly at resident 3. *Later that evening, LPN D spoke with resident 3 who reported that cook J had used an inappropriate tone and language toward her and told her to starve. 6. Interview on 6/26/25 at 1:58 p.m. with director of EVS C regarding the 5/8/25 FRI for resident 3 revealed: *He had received a call from CM B informing him of the incident involving cook J. *He entered the facility through the kitchen's backdoor, approached cook J, and informed him that his employment was terminated. Cook J was then escorted out of the building. *Upon exiting the building, cook J directed vulgar language toward director of EVS C. *Following the incident, EVS C apologized to resident 3 and informed her that cook J was no longer employed at the facility. 7. Interview on 6/26/25 at 2:09 p.m. with dietary supervisor F regarding the 5/8/25 FRI for resident 3 revealed: *He completed the education that included how to talk to residents for the all dietary staff on 5/13/25. *He continued to visually monitor staff interactions with residents to ensure appropriate conduct. *He was bringing all relevant information to the QAPI (Quality Assurance and Performance	F 600		

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F 600	Continued From page 4 Improvement) meetings. *Prior to the incident with resident 3 cook J had received multiple write-ups for other violations including smoking on the premises, inappropriate behavior toward staff and management, and call-ins. 8. Review of cook J's personnel file revealed: *His pre-employment background checks identified no areas of concern. *He had received abuse and neglect, patient rights, and service excellence trainings on 12/11/24. *On 2/23/25 he received a written warning for smoking on campus. *On 4/3/25 he received a written warning for not being courteous to another caregiver or the supervisor/manager. *On 4/17/25 he received a final warning for refusal to follow the policy for call-ins. *On 4/21/25 no warning but a write-up for refusal to follow directions from management. *On 5/8/25 was his last day of employment. 9. Interview on 6/26/25 on 3:30 p.m. with CM B regarding the 5/8/25 FRI for resident 3 revealed: *She had received a call from LPN D that evening informing her of the incident with cook J. *She contacted director of EVS C, who stated he would address the situation. *Director of EVS C later called back to inform her that cook J's employment had been terminated and that he had been escorted out of the facility. *CM B stated LPN D completed an internal incident report, which was used for safety and QAPI meetings. *She conducted an all-staff meeting on 5/14/25, which included education on recognizing and reporting all forms of abuse.	F 600		

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F 600	Continued From page 5 The provider implemented actions to ensure the deficient practice does not recur was confirmed after record reviews and interviews revealed the facility had followed their quality assurance process, education was provided to all staff regarding recognizing and reporting abuse. Dietary staff education was provided on how to speak to residents, 10 strategies for communication with nursing home residents, and professional conduct. Monitoring of staff interactions with residents to ensure appropriate conduct. Observation and interviews revealed staff understood the education provided. Based on the above information, non-compliance at F600 was determined on 5/8/25, and the provider's implemented 5/14/25 corrective actions for the deficient practice confirmed on 6/25/25, the non-compliance is considered past non-compliance.	F 600		
F 689 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 observation, record review, South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, interview, and policy review, the provider failed to identify and	F 689	Heating units have been disabled. Electric supply has been locked out to eliminate power to the heating unit. All residents have potential exposure to the base board heaters. Base board heating units will be covered with safety shields to prevent residents from touching the heating unit.	7/23/25

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F 689	Continued From page 6 implement interventions to prevent one of one sampled resident (2) from having been burned by a baseboard heater. Findings include: 1. Observation on 6/25/25 at 11:15 a.m. of the lounge area next to the nurses' station revealed: *An open area with large windows that extended from the ceiling to close to the floor. *Beneath the bottom of the windows were two separate metal baseboard heating units. They were cool to the touch. -There were temperature control knobs for each unit that were accessible and able to be adjusted by turning the knobs. -Stickers on the top of each of those heating units read: "Caution: High Temperature." Review of resident 2's electronic medical record (EMR) revealed: *Her admission date was 3/25/25 and her primary diagnoses included pain related to malignant colon cancer, diabetes, and heart disease. *Her 3/31/25 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. *A 6/12/25 nurse progress note: "Resident complained of right hand pain. This writer approached resident and hand was red and swollen, outer layer of skin was flushed. I asked resident why she got so close to the baseboard heater, she replied that her hand was cold." -The medical provider was notified of the incident and recommended a cold pack be applied to the affected area for ten minutes on then ten minutes off and the resident's hand was to remain elevated for eight hours. *Resident 2 was transferred to the attached emergency department during the early morning hours of 6/13/25 for a medical condition unrelated	F 689	Base board heating units will only be turned on and heat regulated by plant operations director or designee. The plant operations director or designee will monitor the baseboard heat temperature weekly to ensure the unit is not exceeding 120 degrees. Power will only be supplied to these heaters during the winter months. The plant operations director or designee will monitor the baseboard heater temperature weekly while in operation and ensure protective covers are in place. The Plant operations director or designee will report audit results to the quality assurance team monthly for 3 months. In the winter months (December-March) the plant operations director or designee will monitor the heat temperature and report results to the quality assurance team monthly during these months for further recommendation.	

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F 689	Continued From page 7 to the burn. She has discharged from the facility on 6/17/25. Interview on 6/25/25 at 11:30 a.m. with certified nurse aide (CNA) E regarding resident 2 revealed: *The resident was "always cold." -She often sat in front of the windows by the baseboard heaters in the lounge area next to the nurses' station to warm up. *The resident was able to move her wheelchair independently to and from that area. *CNA E had not known of any other instances of the resident having been burned by the baseboard heaters except for the 6/12/25 incident. *Resident 4 sat in his wheelchair and resident 5 sat in a recliner in that same area on a regular basis. -CNA E had not known of any instances of them or other residents having been burned by the baseboard heaters. Interview on 6/25/25 at 12:45 p.m. with director of environment services (EVS) C revealed: *There was a primary heat source for the lounge area next to the nurses' station. The baseboard heaters in that lounge were able to supplement the primary heat source if that was needed. *There was unrestricted access to the temperature control knobs on the baseboard heaters to have turned them on and adjusted the temperature. *He had not known until after the 6/12/25 incident how hot the metal around those baseboard heaters was capable of reaching after they were turned on. -Using an infrared heat gun with the temperature knob turned to 50%, the temperature of the metal	F 689	The administrator or designee in collaboration with the medical director will review, revise, create as necessary policy and procedures to ensure residents are adequately assessed for their risk of burns including ensuring all areas of the facility are evaluated for the potential of burn-related injuries. The procedure will include reassessment of residents and a review of the environment for potential burn injuries. The director of nursing or designee will will educate all staff regarding their role and responsibilities to help ensure the safety of residents.	

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F 689	Continued From page 8 on the baseboard heater had reached 100-115 degrees Fahrenheit (F). With the knob turned to 75%, the temperature of that metal had reached 130 degrees F. --Temperatures above 120 degrees F were capable of causing burns. *The baseboard heater units should have been, but had not been identified as an accident hazard prior to the 6/12/25 incident for resident 2. Telephone interview on 6/25/25 at 1:40 p.m. with licensed practical nurse (LPN) D regarding resident 2 revealed: *The resident often sat in her wheelchair in front of the large windows in the lounge area next to the nurses' station because there were baseboard heaters beneath those windows. She regularly had stated that she was cold. *On the evening of 6/12/25, LPN D said the resident sat in the above location after dinner until 8:30 p.m. She was awake and alert. -LPN D had observed the resident leaning forward in her wheelchair during that time, but had thought nothing of it. *At 8:30 p.m. the resident reported to LPN D that her hand hurt. She had been "warming her hands up" on the baseboard heater. *LPN D observed the resident's hand and found it was red and swollen. *He had not known: -The baseboards had posed a burn hazard to someone who had been in close proximity to them. -The heaters had accessible knobs that regulated the temperature. -If resident 2 or any other resident had ever been burned by those baseboard heaters prior to the 6/12/25 incident.	F 689		

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F 689	Continued From page 9 Interview on 6/25/25 at 2:00 p.m. with lead resident care manager (CM) B revealed: *In the year that she had been employed by the facility, the baseboard heaters had not been used in the above lounge area. -Nothing had been done proactively to identify or prevent an accident from having occurred related to those heaters because "the [baseboard] heaters had never been an issue [before 6/12/25]." *When she felt the baseboard heaters the morning of 6/13/25, they were still warm. She had notified Director of EVS C and the breakers to those baseboard heaters were turned off and remain off to prevent further incidents from occurring. On 6/25/25 at 3:15 p.m. an Accident Prevention and Resident Safety policy was requested from lead resident CM B. At 4:45 p.m. Chief Nursing Officer A and lead resident CM B provided an Accident and Incidents Investigating and Reporting policy. The provider did have the policy that had been requested.	F 689		