STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A140	A. BUILDING _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUSTER CARE AND REHAB CENTER	1065 MONTGOMERY ST CUSTER, SD 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
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 4/23/25. Areas surveyed included fall notifications to the South Dakota Department of Health (SD DOH) and fall investigations, accident assessments, resident elopement, and the provision of medically-related social services. Custer Care and Rehab Center was found not in compliance with the following requirements: F610, F689, and F745.	F 000		
F 610 SS=D	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 record review, interview, and policy review, the provider failed to ensure one of one cognitively impaired sampled resident's (1)	F 610		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Madison L. Barta
TITLE: Administrator
(X6) DATE: Rev. 5/16/25

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 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.

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F 610	Continued From page 1 unwitnessed fall had been thoroughly investigated to rule out potential abuse or neglect. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted to the facility on 6/19/24. Her diagnoses had included chronic obstructive pulmonary disease, diabetes, depression, anxiety, and chronic kidney disease. -The resident used supplemental oxygen at night. *A 2/10/25 nurse progress note indicated the resident was found sitting on her floor next to her recliner at 2:30 a.m. that morning. The resident had an unwitnessed fall. -She had a skin tear to her right upper arm related to the fall. She had not verbalized having any pain. *A 3/24/25 care conference note indicated the resident was alert and oriented to person and place. She was able to make her needs known. She was able to propel herself in a wheelchair throughout the facility. She had required the assistance of one staff for her activities of daily living and toileting needs. *Her 4/2/25 Brief Interview for Mental Status (BIMS) assessment score was 8. That indicated she was moderately cognitively impaired. Interview on 4/23/25 at 12:20 p.m. with licensed practical nurse (LPN) C regarding resident 1's above fall revealed: *Resident 1 was able to use the bathroom on her own. She had worn a pull-up briefs. *She was occasionally incontinent of bowel and bladder. That usually had occurred during the night because the resident was "a hard sleeper." *Resident 1 was modest and had not always used her call light when she knew she should have.	F 610	Immediate actions taken include reassessment of facility reporting requirements by administration after education received from surveyor. Through this, the facility has determined that all residents have the potential to be affected. An in-service training will be conducted by the administrator with all direct care staff addressing the circumstances that require reporting including appropriate timeframes. All licensed nursing staff will be in-serviced on the new facility policy for Accidents and Supervision. All falls/ incidents will be reviewed within 24 hours by the nursing management team to ensure appropriate implementation of safety interventions including updating the plan of care as well as appropriate documentation regarding all contributing factors. All licensed nursing staff will be educated on the facility fall protocol expectations for resident assessment, treatment, notification and complete documentation after a fall or incident. This facility has implemented a new IDT form that will be utilized and reviewed the morning following an incident at daily stand up. This form includes a description of the incident, immediate actions taken by staff, delegation of follow-up tasks to care staff and the management team, communications/requests to and from the resident's physician and any results of treatment received outside of this facility. This form also includes a timeline of the incident occurring and when reporting deadlines are, when applicable. These forms will be audited monthly by the Director of Nursing Services for completion and accuracy regarding interventions in place and follow up to prevent repeated incidents when reasonably possible and reported in QAPI monthly for tracking. The director of Nursing Services will conduct a random audit of all resident risk management reports weekly for three consecutive weeks. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated and reported to the appropriate people. Findings of this audit will be discussed at the monthly QAPI meeting. If documentation is found to be incomplete, individual education will be provided to the licensed nursing staff member responsible for the incident in question. The risk management investigation will not be signed off on until the documentation is completed. This audit of risk management will become a core part of the monthly QAPI meetings and will not be discontinued	06/07/25

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F 610	Continued From page 2 *LPN C had worked the day shift on 2/10/25. The overnight nurse had reported the resident's fall to her during the change of shift report. *Resident 1 was still in bed when LPN C checked on her at about 7:30 a.m. on 2/10/25. She was complaining of left hip pain. -The resident was evaluated at the local emergency department (ED). Head and thoracic spine CTs (computed tomography scans), and a hip X-ray were negative for concerns. Review of the 2/10/25 Unwitnessed Fall report and interview on 4/23/25 at 12:00 p.m. with administrator A revealed: *Staff had found resident 1 sitting on the floor next to her recliner at 2:30 a.m. on 2/10/25. -"I wet my bed and was trying to get my puppies out of bed so I could strip it and I lost my balance and landed on my bottom." *Under the "Predisposing Physiological Factors" section of the fall report "Incontinent" was not checked, even though the resident was incontinent at the time of her fall. *There was no indication in the report: -If staff had assisted the resident to change her bedding or her clothing, or if the resident was assisted back to bed for the night after the fall. -What time the resident was last seen in her bed before she had fallen. -If the resident's call light was within her reach before she had fallen. -If the resident was wearing her oxygen at the time of her fall or if her oxygen tubing had contributed to the fall. -What the suspected cause of the resident's right upper arm skin tear found after the fall was from. -What, if any treatment, was provided to the above skin tear. -If the resident would have been a candidate for a	F 610		

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F 610	Continued From page 3 night time toileting schedule. *Administrator A stated the 2/10/25 fall report was reviewed by director of nursing (DON) B for quality assurance (QA). -It was expected DON B had identified the fall report was not fully completed and the fall was not thoroughly investigated. -DON B was not available to interview on this date. *Administrator A was responsible for the supervision of DON B. -She agreed the above fall report lacked the necessary details to have analyzed what changes could have been made to mitigate the likelihood of resident 1 falling again and prevent possible abuse and neglect from occurring. Review of the provider's 10/12/24 Compliance with Reporting Allegations of Abuse/Neglect/Exploitation policy revealed: *"6. Investigation: The facility will investigate all allegations and types of incidents as listed above (including injuries of unknown source) in accordance to facility procedure for reporting/response as described below." *"8. Reporting/Response: The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation. The facility will analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences."	F 610		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

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F 689	Continued From page 4 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 record review, interview, and policy review, the provider failed to ensure residents were accurately assessed to determine their safety risks and potential interventions for: *One of one sampled resident (1) with a history of falls. *One of one sampled resident 2 with a history of elopement. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted to the facility on 6/19/24. *She had fallen on 2/10/25 and required medical care outside of the facility related to that fall. *Her 9/19/24 quarterly Fall Risk Evaluation score was 8. -A score of 10 or greater indicated the resident was at high risk for potentially falling. -The Medication Use section of that evaluation was scored 0 based on the resident not having been administered medications that may increase the risk of falling such as: diuretics, hypoglycemics, and psychotropics. *Review of resident 1's April 2025 medication administration record revealed she had been administered hypoglycemic, diuretic, and psychotropic medications daily since her admission. *The Medication Use section of the 9/19/24 Fall	F 689	The Director of Nursing Services and the MDS Coordinator met with the administrator on May 5, 2025. This management team has determined that all residents have the potential to be affected. Director of Nursing and MDS Coordinator educated by administrator on timely completion expectations of assessments. Updated and more comprehensive fall risk assessments were initiated on all residents, the MDS Coordinator and Charge Nurses will complete these re-assessments. Appropriate revisions will be made to the care plans to reflect all current safety interventions. The revised assessments and care plans will be reviewed with staff involved in the care of each resident by the Director of Nursing and MDS Coordinator. These reviews began on 5/5/25 and will be completed by 5/23/25. The updated fall risk assessments will be completed upon admission, quarterly and with significant change for all residents. The Director of Nursing Services will review each risk management report upon occurrence to ensure appropriate action and completion. The Administrator will complete random weekly chart audits of new admission fall and elopement assessments or any new falls or elopements weekly for three weeks and monthly for three months and review all risk management reports to ensure that appropriate interventions have been put into place to reduce the risk of repeated incidents. Documentation not found to be complete, timely, or accurate will be reviewed with the party responsible and corrected at that time. Audited records will be reviewed at the monthly QAPI meeting for three months, if found to be in compliance the audit will be discontinued at that time.	06/07/25

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F 689	Continued From page 5 Risk Evaluation should have been scored 4 for a total evaluation score of 12. 2. Continued review of resident 1's EMR revealed she: *Had no quarterly Fall Risk Evaluation completed after 9/19/24. *Had no Fall Risk Evaluation completed after her 2/10/25 fall. Interview on 4/23/25 at 11:30 a.m. with administrator A regarding resident 1 revealed: *The purpose of the Fall Risk Evaluation was to determine a resident's fall risk and implement interventions to prevent falls. -It was important those evaluations were accurately completed in a timely manner to enhance a resident's safety. *She agreed the resident's 9/19/24 Fall Risk Evaluation was incorrectly scored by the previous director of nursing (DON) who had completed it. *She stated residents' Fall Risk Evaluations were expected to have been completed at admission, quarterly, and after a resident had fallen. -Resident 1 had no quarterly Fall Risk Evaluations completed after 9/19/24. -No Fall Risk Evaluation was completed after the resident's 2/10/25 fall. *It was DON B's responsibility to have completed those evaluations at the expected times of admission, quarterly, and after each resident fall. -DON B was not available on 4/23/25 to interview. On 4/23/25 at 10:45 a.m. a Fall Risk Assessment policy was requested from administrator A. She stated they did not have a policy for that. 3. Review of resident 2's EMR revealed: *His admission date was 3/24/25.	F 689		

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F 689	Continued From page 6 *His 3/24/25 Elopement Risk Evaluation score was 0 indicating he was not at risk for elopement. *A "yes" response on that evaluation to any of the following questions would have indicated he was at risk for elopement: -A history of elopement. -A history of attempting to leave the facility without informing staff. -Verbally expressing a desire to go home, packing belongings to go home or staying near an exit door. -Wandering behavior a pattern or goal-directed. *On 4/13/25 resident 2 had eloped from the facility. *His 4/13/25 post-Elopement Risk Evaluation score was 0 indicating he was not at risk for elopement. *The question of the resident having an elopement history was marked no. -It should have been marked yes to have accurately identified resident 2 as having an elopement history and being at risk for elopement. Interview on 4/23/25 at 3:15 p.m. with administrator A regarding resident 2's 4/13/25 post-Elopement Risk Evaluation revealed: *The purpose of the Elopement Risk Evaluation was to determine a resident's elopement risk and implement interventions to prevent elopement. -It was important those evaluations were accurately completed in a timely manner to enhance a resident's safety. *She agreed the resident's 4/13/25 Elopement Risk Evaluation was incorrectly scored by DON B. -It should have reflected the resident's 4/13/25 elopement history to have identified resident 2 was at risk for future elopements. *DON B was not available during the survey to	F 689	A new elopement risk assessment tool implemented by this facility and completed on all residents previously identified as at risk for elopement. Elopement Identification tool implemented and completed for all residents identified. All licensed nursing staff will receive education on proper completion of this assessment and identification tool by the Director of Nursing and Social Services Director. The identification tools will be kept at the nurses station ready for use if and when necessary. This new assessment will be completed on all residents upon admission, quarterly, and with significant change. The data containing the resident population who are identified as an elopement risk will be tracked and reported on at monthly QAPI meetings and nursing staff in-services. This information will be audited with the fall risk audits and completed based off of the same schedule.	06/07/25

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F 689	Continued From page 7 interview. Review of the provider's December 2023 Elopements and Wandering Residents policy revealed "3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk..."	F 689		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. 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 assess one of one sampled resident (2) for potential psychosocial harm after he had eloped (left without staff knowledge) from the facility. Findings include: 1. Observation on 4/23/25 at 11:00 a.m. of resident 2 revealed: *He had independently walked to the nurses' station and was speaking to administrator A in a frustrated tone. -Administrator A had reminded the resident he was not able to smoke inside the facility. -Resident 2 accepted that response and walked back to his room. Review of resident 2's electronic medical record	F 745	The Social Services Director and Administrator met on May 6, 2025. The social services director was in serviced on regulation F745. This management team has determined that all residents have the potential to be affected, and the Licensed Social Work Consultant will be involved to help guide this plan of correction in order to prevent future systemic failures. A new psychosocial interview will be conducted on any residents after a potential traumatic incident/ accident occurs in order to monitor their wellbeing. This interview will be documented in the EMR via a progress note. Following incidents, the social services director will complete documented interviews with the resident daily for three days and weekly for two weeks. During this time, a new mood assessment will be conducted and referral made to behavioral health services if evidenced as necessary through resident interviews. These interviews will be documented in the EMR via a progress note. The social services director will report potential traumatic incidents and their follow-up actions to the administrator and social services consultant monthly to ensure appropriate assessments completed and action plans were implemented to the plan of care. This report will be reviewed by the QAPI committee monthly for six months.	06/07/25

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F 745	Continued From page 8 (EMR) revealed: *He was admitted to the facility on 3/24/25. *His diagnoses included a bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), a history of prostate cancer, alcohol abuse, unspecified intracranial (head) injury with traumatic brain injury, and nicotine dependence. *His 3/24/25 Brief Interview for Mental Status (BIMS) assessment score was 5. That indicated the resident had severe cognitive impairment. *Resident 2's 3/24/25 Elopement Risk Evaluation score was 0. That indicated he was not at risk for elopement. *On 4/13/25, resident 2 eloped from the facility. -There was no documentation to support social services designee (SSD) D had assessed the resident for any negative psychosocial outcome he may have had as a result of that elopement. Review of the provider's 4/14/25 SD DOH FRI revealed: *On 4/13/25 resident 2 had walked out of the facility with volunteers from a church group who had not known he was a resident. -The resident had attended the church group's church service that day. *After exiting the facility, the resident had walked to an ambulance service located a short distance from the facility. -The ambulance service had thought the resident was homeless and intoxicated, and they notified local law enforcement. *A background check completed by local law enforcement revealed the resident had an outstanding warrant in a nearby community. He was transported to that community by the local law enforcement. *After administrator A communicated with local	F 745		

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F 745	Continued From page 9	F 745		

law enforcement regarding resident 2's circumstances, arrangements were made for the resident to return to the facility.
-A breathalyzer test was completed by local law enforcement upon resident 2's return to the facility. It was negative for alcohol ingestion.
*Local law enforcement disclosed to administrator A, that while resident 2 was in the other county's custody, "[resident 2] was handcuffed and [resident 2] had mentioned that his wrists were sore from that."
-Director of nursing (DON) B's post-elopement skin assessment of resident 2 revealed "redness to [resident 2's] wrists."
*When DON B had spoken privately with the resident after the elopement, he was "concerned [about] what he had done wrong, not understanding why they tried to arrest him, and that he had just wanted to go for a walk."

Interview on 4/23/25 at 1:30 p.m. with resident 2 revealed:
*He was awake and lying on top of his bed. His speech was unclear and difficult to understand. He answered basic questions without providing details or an explanation of his thoughts.
*Regarding the 4/13/25 elopement, resident 2 had remembered walking outside of the facility with a group of people. He had not told the facility staff he was leaving.
-He was "taken away" after he had left the facility, but he was unable to state by whom. They (presumably law enforcement) thought he had "escaped." He was "scared".
*Resident 2 stated he was comfortable at the facility and he had no complaints.

Interview on 4/23/25 at 1:45 p.m. with SSD D regarding resident 2's elopement revealed she:

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F 745	Continued From page 10 *Had spoken with resident 2 since the elopement, but she had not discussed the elopement with him even though she had known the event was traumatic for him. -Had no documentation to support she had assessed the resident for potential psychosocial harm related to that event. *Agreed it was her responsibility to have supported resident 2's psychosocial well-being following the event. That could have included interventions such as: -Providing him opportunities to express his feelings about that event to her. -Arranging for the resident to have been evaluated by a mental health provider if that was indicated. -Observing the resident for changes in his mood and behavior since the event (activity participation, appetite, sleeping pattern, irritability, etc.). -Interviewing staff regarding any changes in the resident's mood and behavior since the event. -Reviewing the resident's mood and behavior documentation and then analyzing it to support or refute changes that may have been related to the event. -Documenting in resident 2's EMR her interventions in response to the resident's 4/13/25 elopement. Interview on 4/23/25 at 2:05 p.m. with licensed practical nurse (LPN) C regarding resident 2's elopement revealed: *She worked the day resident 2 had eloped. *He was "terrified" after he was returned to the facility following the elopement. -He had stayed in his room after he was returned, and anytime he had stepped outside of his room he was insistent that a staff member knew he had	F 745		

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CUSTER CARE AND REHAB CENTER	1065 MONTGOMERY ST CUSTER, SD 57730

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F 745	Continued From page 11 left his room. Interview on 4/23/25 at 3:15 p.m. with the administrator A regarding resident 2 revealed: *The events surrounding his elopement had been traumatic for the resident. *She confirmed there was no documentation to support SSD D had assessed resident 2 for potential psychosocial harm post-elopement based on his known trauma related to that event, but she should have. *SSD D had not followed the provider's policy (below) related to her post-elopement responsibilities for resident 2. Review of the provider's December 2023 Elopements and Wandering Residents policy revealed: *6. Procedure Post-Elopement: -"c. A social service designee will re-assess the resident and make any referrals for counseling or psychological/psychiatric consults." -"g. Documentation in the medical record will include: findings from nursing and social service assessments, physician/family notification, care plan discussions, and consultant notes as applicable."	F 745		