STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435043	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET , SPEARFISH, South Dakota, 57783

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F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/8/25 through 7/9/25. Areas surveyed included accidents, dietary services, physical environment and quality of care related to a resident fall and an elopement. Spearfish Canyon Healthcare was found not in compliance with the following requirements: F689 and to have past noncompliance at F684.	F0000		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, observation and policy review the provider failed to ensure the safety of one of one sampled resident (2) when the resident left the facility without staff knowledge or staff supervision (eloped). This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include: 1. Review of the provider's 6/2/25 SD DOH FRI submitted at 6:50 p.m. to the SD DOH revealed: *On 6/1/25 at 6:52 p.m., camera footage showed that resident 2 was sitting in her wheelchair by the front entrance doors.	F0684	"Past Noncompliance - no plan of correction required"	

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F0684 SS = D	Continued from page 1 *At 6:53 p.m., resident 3's spouse, who was visiting, opened the front entrance door, stepped aside, and held the door open as resident 2 exited the building. *At 6:54 p.m., certified medication aide (CMA) L observed resident 2 outside with other residents and with resident 3's spouse. -CMA L went outside and told resident 3's spouse that resident 2 needed staff supervision when outside. * At 6:54.12 p.m., CMA L brought resident 2 back into the facility. -Resident 2 was assessed for injuries by the nurse on duty and was not injured. *A Wander Guard bracelet (door alarm activating bracelet) was placed on 6/1/25 with the notification and consent of her son, who was her power of attorney (POA). *The director of nursing (DON B) and the physician were notified on 6/2/25 via HUCU (a secure healthcare communication platform). *Her 4/8/25 elopement risk assessment determined she was not at risk for elopement. *She had not demonstrated any recent exit seeking behaviors in the facility. *Letters were sent to family members educating them to ensure a staff member was asked prior to assisting residents out of the facility. *A sign was posted in the entry way that read the following: -"Attention Visitors." --"Please do not let a resident out without checking with a staff member first." ---"Make sure to look at your surroundings before exiting." *Her care plan was reviewed. *Elopement education and facility reporting education was completed with all facility staff. 2. Review of resident 2's electronic medical record	F0684		

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F0684 SS = D	Continued from page 2 (EMR) revealed: *She was admitted on 1/22/24. * Her 4/11/25 Brief Interview for Mental Status (BIMS) assessment score was 7, which indicated she was severely cognitively impaired. *She was assessed for elopement and wandering risks upon her admission to the facility, quarterly with her Minimum Data Set (MDS) and as needed with her resident monitoring activity. -Her 1/9/25 and 4/8/25 elopement risk assessments determined she did not exit seek, and was not at risk for elopement. -Her 1/9/25 wandering risk assessment determined she had wandering behavior, a Wander Guard bracelet was indicated, and consent had been obtained. -Her 1/23/25 and 4/8/25 wander risk assessments determined she did not wander, and a Wander Guard bracelet was not indicated. *A "Head-Toe" skin evaluation and a pain assessment were completed for resident 2 on 6/1/25 at 6:50 p.m. *A wandering risk assessment was completed for resident 2 on 6/1/25, it determined she needed a Wander Guard bracelet since she exited the front entrance door of the facility. *Her physician orders were updated on 6/2/25 for the use of the Wander Guard bracelet. -Nursing staff were to check the Wander Guard bracelet twice daily for it's placement and functioning. 3. Review of resident 2's current care plan dated 4/24/25 revealed: *She used a wheelchair independently for moving around the facility. *She had no history of exit-seeking or elopement. *She occasionally required supervision. *Her current care plan dated 4/24/25 was reviewed and revised on 6/2/25 for risk of wandering and eloping.	F0684		

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F0684 SS = D	Continued from page 3 4. Observation on 7/8/25 at 9:45 a.m. of the facility entrance doors revealed: *A sign was posted on the front entrance door to alert visitors to check with staff before assisting a resident outside. Visitors and staff were to look around for residents in the area before exiting the door. *The other exit doors throughout the facility had key code access panels for staff to enter codes to unlock those doors. 5. Interview on 7/8/25 at 11:30 a.m. with administrator A regarding resident 2's elopement revealed: *Letters were generated on 6/5/25 by receptionist M to send or distribute to families regarding education on resident safety. -The letters were sent to the residents' power of attorneys (POA's) listed as number one on file. -Visitors/family members were to be aware of their surroundings with residents with dementia (a decline in mental ability, such as memory) or Alzheimer's diseases(a progressive disease that destroys memory and other mental functions). -Visitors/family members were to check with staff before assisting a resident outside. 6. Observations on 7/8/25 between 1:30 p.m. and 2:10 p.m. in hall 100 and the common area between the 100 and 200 halls of resident 2 revealed: *Resident 2 was sitting in her wheelchair and slowly propelled herself down the hall. *She was pleasantly confused and answered simple questions appropriately. *She entered the common area and sat and watched the birds in the display. *She appeared content and happy bird watching. *She had no observed aimless wandering or exit seeking behaviors. *The Wander Guard bracelet was on her left ankle.	F0684		

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F0684 SS = D	Continued from page 4 7. Interview on 7/8/25 at 1:59 p.m. with registered nurse (RN) K regarding resident 2 revealed: *Resident 2 wandered in her wheelchair daily throughout the halls. -She usually stayed in hall 100 near the nurse's station when she was awake and in her wheelchair. -She was content in the common area (bird room) watching the birds or television. *RN K was not aware of any attempts made by resident 2 to elope prior to the 6/1/25 incident. *She indicated that resident 2 had not attempted to exit seek or elope while RN K had been on duty during previous shifts. 8. Interview on 7/8/25 at 2:04 p.m. with certified medication aide (CMA) L regarding resident 2's elopement revealed: *Resident 2 would only wander in the hallways in her wheelchair. *CMA L felt that the incident was an isolated incident. *Resident 2 did not exit seek and had never eloped from the building before. *Resident 2 seemed content to sit out by the nurse's station near the common area. 9. Interview on 7/8/25 at 2:09 p.m. with administrator A and director of nursing (DON) B regarding resident elopement revealed: *The front entrance doors were the only doors visitors could enter and exit the facility. -A sign was posted on that door to alert visitors and asking staff before assisting residents outside. *Education was provided to new hires and at least annually on resident wandering, elopement, reporting, and the door alarm system. *Elopement education and facility reporting education was completed with all facility staff on 6/2/25.	F0684		

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F0684 SS = D	Continued from page 5 *Residents were assessed upon admission, quarterly with MDS and as needed with resident monitoring activity for wandering and elopement risks. *Elopements, facility reported, and non-facility reported incidents were tracked and discussed in the monthly quality assurance and process improvement (QAPI) meetings regarding trends and audit findings. 10. On 7/8/25 between 3:30 p.m. and 3:46 p.m. random residents' POA's were contacted to confirm they had received the 6/5/25 letter. *Two of four resident POA's confirmed the 6/5/25 letter was received. 11. Interview on 7/8/25 at 3:54 p.m. with resident 3's spouse in hall 200 revealed: *She received verbal education from a staff member on the day of the incident. -The staff member told her that resident 2 needed staff supervision if she was outside and that she should ask staff to assist the resident outside. -She indicated that she also wrote a statement about the incident that had occurred and signed it for the facility. -She verified receiving the letter in the mail from the facility about resident safety and understood to ask staff to assist residents outside. Review of the provider's Quarter 3, 2018 Elopements policy revealed: *The provider followed their policy and procedure related to a missing resident. *The elopement was reported timely, and it was determined that resident 2 was not authorized to be outside without staff knowledge or staff supervision. Review of the provider's revised 6/10/25 Resident Alarms policy revealed: **Policy Explanation and Compliance Guidelines: -Wander/elopement alarms- includes devices such as	F0684		

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F0684 SS = D	Continued from page 6 bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn/attached to the resident that alert the staff when the resident nears or exits an area or building. This includes devices that are attached to the resident's assistive device (e.g., walker, wheelchair, cane) or other belongings." *Identification of risk: -Each resident shall be assessed for fall and elopement risk upon admission and periodically thereafter as part of the comprehensive assessment process." *"Implementation of interventions. -Alarms shall be initiated only to address a specific medical symptom or unique risk, when the benefit of the alarm outweighs the risk associated with its use." *"Monitoring and modification: -Supervision shall be provided to the resident in accordance with the resident's plan of care. -When alarms are utilized, additional monitoring shall be provided, including but not limited to: –1. Verifying alarms are used in accordance with the resident's care plan. –2. Verifying alarms are working properly, at least once per shift, per facility protocol." The provider's implemented actions to ensure the deficient practice does not recur was confirmed onsite on 7/9/25 after observations, interviews, and record reviews revealed the facility had followed their quality assurance process and action plan for tracking and trending incidents and: *Resident 2 had a Wander Guard bracelet placed on 6/1/25 after the incident. *A wandering risk assessment was completed for resident 2 on 6/1/25, which determined she needed a Wander Guard bracelet after she exited the front entrance door of the facility. *Education on resident safety and supervision was provided to resident 3's spouse on 6/1/25. *There was a plan to include the following in the	F0684		

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F0684 SS = D	Continued from page 7 provider's SD DOH FRI final report: -Nursing staff were checking the functioning and placement of the Wander Guard bracelet on resident 2 twice a day. -Resident 2's physician orders were verified and her care plan was reviewed and revised. -Resident 2 had a wandering risk assessment and an elopement risk assessment completed upon her admission, quarterly with her MDS and as needed with her monitoring activity. -New resident admissions will have wandering and elopement risk assessments completed upon admission, quarterly with their MDS, and as needed with their monitoring activities. -The facilities policies and procedures regarding elopement and wandering residents were reviewed. -Re-education about resident wandering, elopement, safety and reporting was provided to all facility staff on 6/2/25. -New hire education about wandering, elopement, resident safety, and reporting will continue as a part of the facilities orientation process. -Letters educating families on resident safety and supervision were sent to the POA's on 6/5/25. -Resident 3's spouse confirmed verbal and written education was received on 6/1/25 and on 6/9/25. -Interviews with staff confirmed they knew the requirements for elopement and were aware of the procedures to address a resident who had eloped. -Signage was posted on the front entrance door for visitors not to assist residents out of the building without checking with staff. Based on the above information, non-compliance at F684 occurred on 6/1/25, and based on the provider's implemented corrective actions on 6/9/25 and additional corrective action plans, for the deficient practice confirmed on 7/9/25, the non-compliance is considered past non-compliance.	F0684		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices	F0689		

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F0689 SS = G	Continued from page 11 after the dining room was served, to the residents in their rooms. *Nursing staff were only involved in meal service if a resident required assistance. *They confirmed receiving education about the safe positioning of residents for meals and hot liquid safety. *Nursing staff had access to a thermometer that was kept near the microwave in case food or beverages needed to be warmed by nursing staff. 5. Interview on 7/8/25 at 2:35 p.m. with dietary aide F revealed: *Dietary aides delivered trays to residents in their rooms. *If a resident was in bed when a tray was delivered, she would turn the call light on to notify nursing staff that the tray had been delivered. *Coffee and hot water were dispensed from the coffee machine into carafes and kept on the cart for room meal trays. *If a resident requested coffee or hot water for tea, she would pour the beverage into a coffee cup, place a lid on it, and bring the covered cup into the resident's room. *She stated she had received education as recently as "a couple of days ago" about hot liquid temperatures and safety. 6. Interview on 7/8/25 at 4:00 p.m. with dietary supervisor G revealed: *She had been the dietary supervisor since 6/16/25. She had worked in the kitchen as a cook and a dietary aide before she began the dietary supervisor role. *She had received education on hot liquid safety and the proper procedure for preparing hot liquids using hot water from the coffee machine. *The coffee machine was calibrated to maintain coffee and hot water at a specific temperature throughout the day, which she thought was 132 or 134 degrees. *The coffee machine's temperatures were to be checked	F0689	Identification of Others All residents have the potential to be affected. Systematic Changes All residents were audited for Hot Liquid Safety Evaluations to ensure accuracy on March 25, 2025. Hot Beverage audits were started on March 29, 2025, through the end of May 31, 2025, with no further issues. Directed In-service training was held on July 29, 2025, with facility dietician leading the meeting. She trained all dietary staff including cooks, aides, and the dietary manager. Directed In-service training was held also on July 31, 2025, with the facility Administrator leading the meeting. Therapy staff prepare a Men's Group each Friday for a few residents. She trained therapy staff, who were in the building, including all disciplines of PT, OT, ST, and the DOR. DOR contacted those who were not present via phone on July 31. Those therapy staff members will sign off on the education on their next shift.	

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F0689 SS = G	Continued from page 12 twice daily, once in the morning and once in the afternoon. *Soups were served in bowls; if soup was included on a room tray, it was to be covered with a lid. *Soups served in the dining room did not have lids on them. 7. Interview on 7/9/25 at 10:37 a.m. with cook H revealed: *The day of the burn incident was only his second or third day working at the facility. *He had prepared the broth using water from the stovetop kettle rather than the facility's established procedure of using hot water from the coffee machine. *He had not checked the temperature of the broth before it was sent out on a room tray. *He stated that they are now checking the temperatures of items such as soup that are heated in the microwave. *When temperatures are checked for items like soup after microwave heating, there was no formal log to record those temperatures, but the temperature was written on the resident's meal ticket. 8. Interview on 7/9/25 at 11:40 a.m. with administrator A and director of nursing (DON) B revealed: *The meal tray delivery process was adjusted through the facility's Quality Assurance and Performance Improvement (QAPI) program. Dietary staff were to deliver room trays to resident rooms and set the trays up for residents. They would notify nursing staff if a resident was not sitting up or needed to be positioned safely for meals. *Their audits indicated that revised practice was being followed by staff. *They reported experiencing significant turnover in the dietary department, including the dietary management team. *Administrator A confirmed that cook H had not followed proper procedure when he prepared the broth, and did not check the temperature of the broth before it was sent out on a room meal tray to be delivered to the	F0689	Both meetings discussed the revisions of facility policy of Safey of Hot Liquids to include additional interventions. All interventions named on the policy are as follows: 1) Maintaining a hot liquid serving temperature of not more than 155 degrees Fahrenheit, 2) Adaptive equipment recommended by OT post-assessment to be provided for each resident, 3) Serving hot beverages in a cup with a lid, 4) Encourage residents to sit at a table while drinking or eating hot liquids, 4) Providing protective lap covering or clothing to protect skin from accidental spills, 5) Residents identified as at risk will be indicated on diet card to alert staff members, 6) Staff supervision or assistance with hot beverages based off risk assessment, 7) Any equipment identified as not maintaining appropriate temperatures will be removed from service until thorough inspection and correction action are taken. As stated in the policy, all food service staff are responsible for monitoring and maintaining food temperatures that comply with food safety requirements but do not exceed recommended temperatures to prevent scalding. Additional details of the Directed In-service training included guidelines on Hot Beverage Safety, Walk-in Cooler Food Storage Chart, processes for food reheating, cooling food methods, and thermometer calibration. Laminated sheets of all guidelines and processes have been hung throughout the kitchen.	

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F0689 SS = G	Continued from page 13 resident. 9. Review of the provider's October 2014 Safety of Hot Liquids Policy revealed: *Policy Statement -"Residents will be evaluated for safety concerns and potential for injury from hot liquids upon admission, readmission, and with any change of condition." *Policy Interpretation and Implementation -"The potential for burns from hot liquids is considered an ongoing concern among residents with weakened motor skills, balance issues, impaired cognition, and nerve or musculoskeletal conditions. -Residents with these or other conditions may suffer from accidental burns and related complications stemming from thinner, more fragile skin that may burn quickly and severely and take longer to heal. -Residents who prefer hot beverages with meals (i.e., coffee, tea, soups, etc.) will not be restricted from these options. Instead, staff will conduct regular Hot Liquid Safety Evaluations as indicated, and document the risk factors for scalding and burns in the care plan. -Once risk factors for injury from hot liquids are identified, appropriate interventions will be implemented to minimize the risk of burns. Such interventions may include: --Maintaining a hot liquid serving temperature of not more than 155 degrees Fahrenheit; --Serving hot beverages in a cup with a lid; --Encouraging residents to sit at a table while drinking or eating hot liquids; --Providing protective lap covering or clothing to protect skin from accidental spills; and --Staff supervision or assistance with hot beverages. -Food service staff will monitor and maintain food temperatures that comply with food safety requirements but do not exceed recommended temperatures to prevent scalding."	F0689	Ad Hoc ran through IDT July 31, 2025, to approve revision of policy as stated above. Ad Hoc will be added to the July Qapi review on August 15th. A temperature log by the microwave has been added to the circulation of daily food temperature logs in the kitchen. Monitoring Food temperature audits were completed March 29, 2025, through May 31, 2025, with no further incidence. The Qapi committee decided the facility was demonstrating sustained compliance and ended the audits on May 31, 2025.	

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F0689 SS = G	Continued from page 9 *Silvadene was applied to the area to treat the skin and prevent further damage. *The doctor and the power of attorney (POA) were notified. *On 3/25/25, resident 4 was seen by a physician assistant for increased lethargy and decreased alertness that had been noted on 3/24/25. She was also evaluated for the burn at that time. *On 3/25/25, LPN Q noted that resident 4 was awake and visiting with staff before breakfast. *On 3/25/25, cook H prepared the broth using water from the stovetop kettle. -The stovetop kettle was normally used to make hot cereal. *Education was completed with all dietary workers to ensure that hot beverages are made from the coffee machine, which also dispenses hot water, at a reduced temperature of 135°F to 140°F. *Hot liquid safety evaluation audits were conducted for all residents in the facility to ensure accuracy. *Facility education was provided to nursing and dietary staff to ensure that: -Nursing staff assisted residents who choose to eat in their rooms with proper positioning prior to meals or beverages being served. -When hot liquids are served, dietary staff must ensure beverages are in a handled cup with a lid and must communicate with nursing staff to monitor residents in their rooms. *Audits were conducted to monitor the temperature of food and beverages, and no concerns were identified. 2. Review of resident 4's electronic medical record (EMR) revealed: *She was admitted on 3/8/25 after surgical repair of a left hip fracture that resulted from her fall at an assisted living facility (ALF) and had been discharged back to that ALF. *She had a Brief Interview for Mental Status (BIMS) assessment score of 13, which indicated she was	F0689	Immediate education was given to cook (H) on March 25, 2025, stating, "when making broth for residents use hot water that comes from the coffee machine, ensure temperature is taken, and is below 140 degrees, if have to use water that is made on stove top must ensure temperature is between 135-140 degrees." Immediate education was given to dietary staff on March 25, 2025, stating, " when providing any hot beverage (this includes coffee, hot water/tea, soups, broths, etc.) you MUST ensure that it has been temped, and they must be placed in appropriate mug (handled coffee cup with a lid)." Hot liquid safety evaluation was captured upon admission, and OT provided a statement on March 25, 2025 stating that "Pt able to demo appropriate BUE gross and fine motor skills to perform self-drinking, feeling and ADL item manipulation with set up, no spillage or dropping of items noted, no tremors present during assessment, no previously identified issues with ability to self-feed/drink since admission to facility". The IDT team started an action plan on March 25, 2025, stating, "all new admit triggers for RD follow up and therapy evaluation needs will be evaluated upon admission review in stand up. Therapy eval and RD eval needs will be added to the White Board for check off." Spearfish Canyon Healthcare's whiteboard is reviewed each morning at the IDT stand up meeting.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET , SPEARFISH, South Dakota, 57783

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F0689 SS = G	Continued from page 10 cognitively intact. *Her diagnoses included a history of transient ischemic attack (TIA) (a "mini-stroke"), age-related macular degeneration (an eye disease typically associated with aging that can cause significant vision loss), fracture of neck of left femur (hip fracture), and tremor (involuntary muscle contraction causing shaking or trembling) unspecified (specific type or cause of the tremor not yet identified). *A 3/26/25 nursing note indicated "Assessed resident right thigh burn today, she has a 2.5 cm [centimeter] area where the blister opened, skin is beefy red with no s/s [signs/symptoms] of infection." *A 4/11/25 discharge summary indicated resident 4 had skin issues described as "Burn to R [right] outer thigh- healing." 3. Interview on 7/8/25 at 1:37 p.m. with certified medication aide (CMA) C revealed: *Dietary staff would deliver room trays to resident rooms. *Some residents routinely chose to eat in their rooms. *Room trays were delivered after the dining room meals were served. *Dietary staff would set up the meal tray for the resident in their room. *CMA C stated that staff had received education about how to safely position residents for eating in their rooms. *She stated that staff had received "a lot" of education about hot liquid safety. 4. Interview on 7/8/25 at 1:48 p.m. with Certified Nursing Assistant (CNA) E and CMA D revealed: *A few residents who chose to eat in their rooms by preference. *If there was a last-minute resident request to eat in their room, staff would call the kitchen to notify dietary staff. *Dietary staff delivered the cart with meal trays,	F0689	An Ad Hoc for burns was added to Spearfish Canyon Healthcare's April Qapi. The Ad Hoc was completed by IDT through Qapi at the end of May because our audits did not show any further incidence. Upon Ad Hoc review during QAPI, interventions were highlighted to show the intervention of dietary bringing prepped and temped food/beverages to rooms and to alert nursing for repositioning needs if hot substances are requested, which was communicated with facility staff. The dietary department had a Directed meeting on April 2, 2025, reviewing the facility policy on Safety of Hot Liquids. Those who could not make the meeting were contacted via telephone. The dietary department met again via in-service on April 9, 2025, where they again reviewed temperatures of hot liquids and temp logs completed each day located throughout the kitchen. April All Staff, held on April 28, 2025, included education regarding hot liquids and risk of burns.	

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F0689 SS = G	Continued from page 8 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 South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, staff interview, and policy review, the provider failed to ensure an environment free of safety hazards for: *One of one sampled resident (4), who sustained a skin burn injury from hot liquid (broth) that was improperly prepared by cook (H) who did not follow the facility's established procedures for safe food preparation and service. *One of one sampled resident (1), who fell when CNA O assisted her to walk without the use of a gait belt. Findings include: 1. Review of the provider's 3/25/25 SD DOH facility reported incident (FRI) revealed: *On 3/25/25 at approximately 8:24 a.m., physical therapist (PT) N answered resident 4's call light. *Resident 4 reported to PT N that she had spilled her broth on her right leg. *PT N immediately notified licensed practical nurse (LPN) Q, who entered resident 4's room at approximately 8:25 a.m. *With resident 4's consent, LPN Q immediately assessed resident 4's leg area and noted redness to the area on her right leg. Resident 4 had no complaints of pain at that time. *LPN Q gently dried the area, ensured resident 4's comfort, and alerted director of nursing (DON) B of the situation.	F0689	Corrective Action Immediate education given to nursing staff on March 25, 2025, stating: "If any hot liquids are requested by residents in their room, dietary will be bringing these temped liquids to the nurse's stations. Nursing should go into the residents' rooms and ensure the resident is properly sitting up prior to bringing in the hot liquids. Review Kardex to ensure no specific interventions are needed for hot liquids. Resident 4 must have a lid and handle when drinking hot liquids."	July 31, 2025

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F0689 SS = G	Continued from page 14 10. Review of the provider's SD DOH FRI submitted on 4/8/25 at 5:06 p.m. regarding resident 1 revealed: *Resident 1 fell on 4/5/25 at 5:30 a.m. when being assisted back from the bathroom by CNA O. *Resident 1 had verbalized that her knees were weak and then CNA O lowered resident 1 to the floor in a sitting position. -Resident 1 had no complaints of pain before or after she was sitting on the floor. -CNA O indicated that she guided resident 1 to the floor gradually by her waist. -CNA O had placed resident 1's thoracic-lumbar-sacral-orthosis (TLSO) brace (a brace used to stabilize and limit motion in the back) prior to ambulating her to and from the bathroom. -Resident 1 had this brace prior to her admission to the facility related to her lumbar (lower back) 3 compression fracture (broken bone). -She was to always wear the TLSO brace when sitting upright and when she was out of bed doing an activity. -The TSLO brace could be removed when she was in bed. -No gait belt (a safety device used to assist resident's with walking) was used by CNA O when she assisted resident 1 with walking to and from the bathroom. -Resident 1 had her front-wheeled walker (FWW) for an assistive device when she was being assisted to the bathroom by CNA O. *Resident 1 was evaluated by the nurse and then three staff assisted her up off the floor. -Resident 1 had no complaints of pain after she was assisted up. *The physician and power of attorney (POA) were notified of the fall on 4/5/25 at 6:44 a.m. *Resident 1 used a portable assist lift (a medical device used to move residents with limited mobility) over the weekend related to her new acute weakness in her legs and pending a therapy consult. -Resident 1 was ambulating with a FWW prior to her fall	F0689	Corrective Action CNA O was given verbal education on 4/5/2025 of gait belt use and policy. CNA O, and facility wide written education on gait belt use and policy was provided and signed on 4/9/2025. Identification of Others All residents have the potential to be affected. Systematic Changes Gait belts were put in all resident rooms, if they were not already present on 4/9/2025. Monitoring DON/Unit Manager/designee will audit 2 resident transfers per week for 1 month beginning on or before August 5, 2025, to determine if gait belts are being used during transfers. Audits will continue for 1 month and then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.	

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F0689 SS = G	Continued from page 15 on 4/5/25. *The therapy staff evaluated resident 1 on 4/7/25 and ordered continued use of the PAL lift related to resident 1's leg weakness. *Resident 1 verbalized persisting pain to her right thigh after the incident on 4/5/25, which was not a new complaint for her. *Resident 1 had a neurosurgery follow-up appointment that was scheduled for 4/8/25 prior to her admission to the facility. -She had a history of a spontaneous lumbar 3 compression fracture that occurred prior to her admission to the facility. *On 4/8/25 resident 1 went to her neurology follow-up appointment. *Resident 1 was sent to the emergency department by neurology on 4/8/25 because of her increased radiculopathy pain. -The emergency room imaging results indicated she had a continued lumbar 3 compression fracture and a new acute (a new break in a bone) and/or subacute (a break in a bone that is between 5 and 13 days old) fracture of the lumbar 4 vertebral body. -Resident 1 was hospitalized on 4/8/25 for treatment of her bilateral lower leg weakness and the lumbar 4 vertebrae fracture. *Her POA, family, and the physician were notified of the above imaging results and her hospitalization. 11. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted on 3/10/25 and currently resided at the facility. **Her diagnoses included wedge compression fracture of the 3rd lumbar vertebrae sequela, wedge compression fracture of the 3rd lumbar vertebrae, subsequent encounter for fracture with routine healing, age related osteoporosis without current pathological fracture, other abnormalities of gait and mobility, abnormal findings of diagnostic imaging of other parts of musculoskeletal system, and unspecified dementia.	F0689		

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F0689 SS = G	Continued from page 16 * Her 6/16/25 Brief Interview for Mental Status (BIMS) assessment score was 12, which indicated she had moderate cognitive impairment. * On 3/10/25 a fall risk assessment was completed which identified her as being at risk for falls. 12. Review of resident 1's 6/30/25 care plan revealed: *Her medications listed on the care plan included: "use of antidepressant, psychotropic, pain, and hypnotic medications which can contribute to gait disturbance and falls." *"I need assistance with my transfers, bed mobility and ambulation." -"I have limitations related to my lumbar fracture." -"Assist [the resident] with one staff person for transfers, walking to/from the bathroom with FWW, and gait belt." *"At risk for falls/injuries related to debility/generalized weakness, poor safety awareness." -"Monitor [the resident] for increased weakness or instability." -"Refer [the resident] to physical/occupational therapy for strengthening exercises and gait training to increase mobility and safety awareness." *At risk for spontaneous and unavoidable fractures related to severe osteoporosis and history of spontaneous compression fractures." -"Assess [the resident's] functional ability for mobility and note changes." -"Assist [the resident] with mobility as needed and using assistive devices e.g., --a. Cane or crutches, --b. Walker." -"Provide and assist [the resident] with mobility by means of wheelchair, walker, crutches, canes as soon as possible. Instruct in safe use of mobility aids." 13. The SD DOH FRI final report included further review	F0689		

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F0689 SS = G	Continued from page 17 of notes and imaging for resident 1 by the management team which revealed the following: *Resident 1 had a diagnosis of osteoporosis (a condition in which bones become weak and brittle) and a history of spontaneous lumbar fractures (bones in the lower back weaken and collapse, often without significant trauma) prior to her admission to the facility. -On 2/23/25 she had acute back pain in the lumbar vertebrae 4 and 5 areas, an x-ray (a medical imaging procedure) was obtained and was negative for fractures. -On 3/2/25 she had worsening back pain, increased weakness and pain to the right thigh, a computed tomography (CT) scan (a medical imaging procedure) was obtained and was positive for an acute compression fracture at lumbar 3 vertebrae. -On 3/2/25 a magnetic resonance image (MRI) (a medical imaging procedure) was obtained and showed a lumbar 3 vertebrae compression fracture and a lumbar 2 nondisplaced acute fracture. --No trauma was identified to cause those fractures. --The lumbar 3 was a spontaneous osteoporosis related fracture. -On 3/8/25 another MRI was obtained of the lumbar spine; this noted the severe lumbar 3 compression fracture. -On 3/10/25 resident 1 was admitted to the facility for rehabilitation with therapy services. -On 4/5/25 resident 1 had an assisted fall to the floor with no use of a gait belt. -On 4/8/25 a chair x-ray was obtained at the neurology department and deemed the lumbar 3 fracture worsened and she had a possible lumbar 4 fracture. -On 4/8/25 in the emergency department, an MRI was obtained and showed the lumbar 3 subacute and lumbar 4 acute/subacute fracture with 30% stature loss centrally. --It was noted that resident 1 had osteoporosis in the setting of the compression fractures. *On 4/8/25 resident 1's physician provided a written statement regarding resident 1's compression fractures.	F0689		

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F0689 SS = G	Continued from page 18 *On 4/9/25 at 8:34 a.m. the POA signed a bed hold (reserving the resident's bed for a temporary absence) for resident 1. *On 4/9/25 at approximately 9:30 a.m. a detective with the local law enforcement called the facility and stated that a family member had called and felt resident 1 had been improperly transferred which led to her fall on 4/5/25 and a report was filed. -No prior calls were received from family to the facility with concerns or questions about resident 1's fall on 4/5/25. *On 4/9/25 DON B and social services director (SSD) P called resident 1's POA to follow up on the police report concerns. -The POA denied she made a report to law enforcement and denied any treatment concerns about resident 1's care. -The POA inquired about gait belt use during the conversation. -The grievance and complaint procedures were reviewed with her. *On 4/10/25 resident 1 was re-admitted back to the facility. 14. Record review on 7/9/25 of resident 1's physician letter revealed: *The above timeline and findings were confirmed and verified in his letter. *He referenced that resident 1 had not experienced any significant trauma to cause the lumbar fractures. *He referenced that with the combination of resident 1's diagnosis of osteoporosis, poor bone density, and underlying bone fragility, resident 1's fractures most likely occurred spontaneously. 15. Record review on 7/9/25 of CNA O's written statements regarding resident 1's fall revealed: *CNA O entered resident 1's room at approximately 5:30 a.m. to find resident 1 sitting on the edge of her bed.	F0689		

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F0689 SS = G	Continued from page 19 *Resident 1 stated, "I need to pee". -CNA O assisted her with applying her TLSO brace and walked with her to the bathroom while resident 1 used her FWW, no gait belt was applied. *After she used the bathroom, resident 1 and CNA O were walking back to resident 1's bed, when she explained that her knees were weak, and she could not walk anymore. *Resident 1 was assisted to the floor by CNA O to a sitting position. - No gait belt was used by CNA O when assisting resident 1. -CNA O indicated that she assisted resident 1 down to the floor by guiding her by her waist. -Resident 1 received two skin tears to her right arm and one skin tear to her left arm from rubbing her arms on the recliner chair during the assisted fall to the floor. *CNA O called for help on her radio. -The floor nurse, and another CNA responded to the radio call. -CNA O indicated that resident 1 did not complain of pain before the incident, during toileting, during walking, or after the incident occurred. 16. Observation and interview on 7/9/25 at 11:43 a.m. with physical therapist (PT) I in hall 100 with resident 1 revealed: *She was ambulating with the use of her FWW with physical therapist (PT) I in the hallway. *Resident 1 was wearing a gait belt around her waist. *Resident 1 had her TSLO brace on. *PT I stated that the staff should always use a gait belt with residents with walking or transferring. *PT I stated that resident 1 walked approximately twenty-five feet with her assistance. -PT I stated that resident 1 had improved but her recent respiratory illness had set her progress back at	F0689		

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F0689 SS = G	Continued from page 20 that time. *Resident 1 denied pain when she walked with PT I. 17. Interview on 7/9/25 at 1:44 p.m. with CNA J regarding the use of a gait belts revealed: *Staff should use a gait belt for residents who needed assistance with walking or transferring. *Gait belts were stored in the resident rooms, behind the door on a hook or on the resident's walker or wheelchair. -Staff could retrieve a gait belt from the storage room if unable to locate in a resident room. *Each resident had their own gait belt. *Staff had been trained on the use of gait belts. -Staff were trained at orientation and annually on gait belt use. 18. Interview on 7/9/25 at 1:51 p.m. with certified medication aide (CMA) C regarding the use of a gait belts revealed: *Gait belts were available for each resident who required assistance. *Gait belts were required for staff to use. *Staff received training on the use of gait belts during orientation and annually. -A registered nurse (RN) educator provided that training. 19. Interview on 7/9/25 with DON B regarding resident 1's fall and gait belt use revealed: *The facility revised their "Use of a Gait Belt" policy on 5/13/25. -Directed staff were required to use gait belts with residents who "cannot independently ambulate or transfer" for the purpose of safety. -She stated the policy had stated before, that staff were to use gait belts with "anyone" who ambulated or	F0689		

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F0689 SS = G	Continued from page 21 transferred. *She indicated that CNA O was educated on gait belt use during her orientation. *She stated that resident 1's fall on 4/5/25 was not a high impact fall and that it was an assisted fall to the floor. *CNA O put resident 1's TLSO brace on her before she walked her to the bathroom. -She indicated that resident 1 was already up at the time and wanted to use the bathroom. -She explained there was a "time restraint" as resident 1 needed to use the bathroom, and CNA O was trying to get her to the bathroom to prevent an incontinent episode. -She added that CNA O and resident 1 used the FWW to walk to the bathroom. *DON B agreed that CNA O should have used a gait belt when she assisted resident 1 to and from the bathroom. *She confirmed that gait belt training and education was completed with all facility staff on 4/9/25. *Residents were to be assessed upon admission and periodically for fall risks. *Resident falls, facility reported, and non-facility reported incidents were tracked in the monthly quality assurance and process improvement (QAPI) meetings to discuss trends and audit findings. 20. Review of CNA O's employment and training records revealed: *She was hired on 3/13/25. *She received orientation education on 2/28/25 from the provider which included: -Transfer Techniques. -How to lift and transfer without injury. -Gait belt use. -Types of Abuse.	F0689		

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SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET , SPEARFISH, South Dakota, 57783

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F0689 SS = G	Continued from page 22 -How to report suspected or actual abuse. -Incident Reporting. *CNA O received re-education on 4/9/25. -Patient Handling. -What is a gait belt. -What is the purpose of a gait belt. -How to use a gait belt. -Choosing a gait belt. -Gait belt training and education. -Safe lifting and movement of residents. *CNA O voluntarily terminated her employment at the facility on 4/29/25. Review of the provider's revised May 13, 2025, Use of Gait Belt policy revealed: **Policy: It is the policy of this facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety." **Policy Explanation and Compliance Guidelines: -Gait belts will be available to all employees. -Applicable employees will receive education on the proper use of gait belt." Review of the provider's revised June 9, 2025, Fall Risk Assessment policy revealed: **It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents." **Policy Explanation and Compliance Guidelines: -3. An "At Risk for Falls" care plan will be completed for each resident to address items identified on the risk assessment and will be updated accordingly."	F0689		