STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A038	A. BUILDING ______ B. WING ______	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTCHMAN LIVING CENTER	**503 WEST PINE** **PHILIP, SD 57567**

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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 3/6/24. The area surveyed was appropriate care of a resident with dementia during a behavioral episode. Scotchman Living Center was found to have past noncompliance with the following requirement: F600.	F 000		
F 600 SS=G	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 review of the South Dakota Department of Health (SD DOH) complaint online report, interview, and policy review, the provider failed to protect one of one sampled resident (20) from mistreatment while receiving care from staff. Findings include: 1. Review of the SD DOH complaint online report revealed the following:	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maureen Cadwell
TITLE: CEO
(X6) DATE: 03/20/2024

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 600	Continued From page 1 *On 2/8/24 at 12:30 p.m. certified nursing assistant (CNA) C reported to registered nurse (RN) B that while providing care in the morning for resident 20, resident 20 had grabbed the back of CNA D's arm and twisted it. -That caused three open abrasions and redness on CNA D's arm. -CNA D had put resident 20's hands between her legs and put her weight on top of resident 20. -Resident 20 began yelling, "You're going to break my arm." -CNA D stated, "You're going to get dressed, and you're not going to hit me anymore." -CNA C told CNA D to ease up [on resident 20], and called out for help from other staff members. -CNA E came into the room and saw that "CNA D to be straddling on top of resident 20 with the resident's arms crossed and the resident yelling get off me, you're going to break my arms." -CNA E then had assisted in helping resident 20 stand up and walk to the dining room. -RN F came to the room as CNA E was walking the resident out of the room. Observation on 3/6/24 at 10:27 a.m. of resident 20 in her room revealed she was in her bed, laying on her left side, with her eyes closed. Observation on 3/6/24 at 11:30 a.m. of resident 20 in the dining room revealed: *Her noon meal was served on a red plate. -She had pushed that plate into the middle of the table. *When asked open-ended questions, she had shaken her head no to each one of those questions with no other response. Review of resident 20's medical record revealed: *She was admitted on 11/29/23.	F 600		

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*Her 12/7/23 Brief Interview of Mental Status score was a 99 indicating she was unable to be interviewed.
*Her diagnoses included dementia with behavioral disturbances and visual loss.
*Her 3/6/24 care plan included the following:
-"Allow sufficient time for dressing and undressing."
-She "requires substantial assistance by 1 [one] staff [member] to dress."
-"At times will refuse morning cares due to preference of sleeping in."
-She was resistive to care.
--"Give clear explanation of care activities prior to an as they occur during each contact."
--"If resident resists with ADL's [activities of daily living], reassure resident, leave and return 5-10 minutes later and try again."
--"The resident is verbally aggressive with staff."
--"The resident has impaired visual function r/t visual loss."

Confidential interview with an employee who wished to remain anonymous regarding the above incident revealed:
*She heard a staff call for help from resident 20's room.
*She went to resident 20's room, and heard yelling that was not unusual, knocked and entered the room.
*She heard CNA D state, "She is not going to [profanity] hit me again."
*CNA C had looked at her and stated quietly to her, "I don't know what to do."
*Resident 20 was on the bed lying on her side.
-CNA D was lying over the top of resident 20.
-Resident 20's arms were crossed and underneath of her.
-CNA D stated, "You are not getting up, she isn't

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going to hit me again."
-The anonymous employee, during the interview, that the tone of resident 20's voice stating, "Don't hurt me" made her ill.
-CNA C and the anonymous employee intervened and assisted resident 20 to stand up.
-CNA D left the room.
-RN F came into the room, looked around, and then left the room.
*As resident 20 walked down the hallway, she stated "Where is the ghost?"
-The employee asked resident 20 who the ghost was and resident 20 responded, "That is what I am going to call that mean lady, a ghost."
*On 2/8/24 after the above incident there was an emergency staff meeting held for all staff regarding abuse and neglect, proper restraining of residents, and how to handle residents with behaviors.

Confidential interview with a second employee who wished to remain anonymous regarding the above incident revealed the following:
*She heard a call for assistance in resident 20's room.
-When she went into the room, CNAs C and D were assisting resident 20 to stand up, and assisting her pulling up her pants.
*Regarding CNA D the anonymous employee stated that CNA D "had a short fuse".

Interview on 3/6/24 at 11:54 with RN B regarding the above incident revealed:
*The incident happened at around 10:00 a.m. while staff were assisting resident 20 in getting up for the day.
*She was notified of the incident around noon time from CNA C.
*She contacted director of nursing (DON) A, who

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was not in the facility at that time.
*The investigation was started.
-CNA D was suspended on 2/8/24 at 1:16 p.m.
-The investigation was completed and was substantiated that abuse had occurred.
-CNA D's employment was terminated on 2/14/24.
*Education regarding abuse and neglect, retaliation, and dementia care was provided to every staff member after the incident on 2/8/24 and before their next working shift.
-Additional education for those same topics was provided to all staff members on February 28, 2024.

Interview on 3/6/24 at 12:06 p.m. with DON A regarding the above incident revealed:
*She was notified on 2/8/24 of the above incident.
-She came to the facility and started educating staff members on abuse and neglect.
-Education was provided to staff members in their monthly meeting.
*Events that were reportable to the SD DOH were included in the monthly Quality Assurance Process Improvement (QAPI) meeting for review.

Review of the provider's revised February 2024 Abuse policy revealed:
*"Subject: Freedom from abuse, neglect and exploitation & [and] reporting
*Purpose: To ensure the facility has followed all the required stops for recognizing and for appropriate reporting and follow up in cases of suspected resident/patient abuse."
*"Policy: Each resident/patient has the right to be free from abuse, neglect, misappropriation of resident/patient property ...Residents/Patients must not be subjected to abuse by anyone, including, but not limited to, facility staff ,other

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F 600	Continued From page 5 residents/patients, consultants or volunteers, staff or other agencies serving the resident/patient, family members or legal guardians, friends, or other individuals." -"C. To assist our facility's staff members in recognizing incidents of abuse, the following definitions are provided:" -"Physical Abuse includes but is not limited to hitting, pinching, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment." -"Mistreatment means inappropriate treatment or exploitation of resident/patient" -"Person Centered Care is care that is individualized by being talored [tailored] to all relevant considerations for that individual, including physical, functional and psychosocial aspects." -"Physical restraint as [is] any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: --is attached or adjacent to the resident's/patient's body --can not be removed easily by the resident/patient. --restricts the residents/patients freedom of movement or normal access to his/her body." *"Subject: Prevention *Purpose: to prevent abuse by providing residents/patients, families, and staff information and education on how and to whom to report concerns, incidents and grievances without the fear of reprisal or retribution. The leadership will assess the needs of the residents/patients in the facility to be able to identify concerns in order to prevent potential abuse." *"Subject: Abuse/Neglect Inservice Training *Purpose: To provide periodic inservice [in-service] training for employees/volunteers on	F 600		

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F 600	Continued From page 6 resident/patient rights and our facility's abuse/neglect prevention program." *"Procedure:" -"5. Dementia training is offered throughout the year via [computerized training system] and staff meeting education, which addresses behavioral issues and approaches." Substantial compliance was confirmed on 2/14/24, after: *Staff member interviews confirmed education regarding dementia, abuse and neglect had occurred. *Review of documented dementia, abuse and neglect education for all staff members. *Termination of CNA D's employment. *SD DOH reports were reviewed during the QAPI meetings.	F 600		