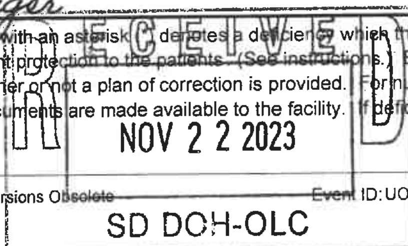
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435120	A. BUILDING ______ B. WING ______	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL NURSING HOME	315 NORTH WASHINGTON ST VIBORG, SD 57070

(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 An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/24/23 through 10/25/23, and from 10/30/23 through 10/31/23. Pioneer Memorial Nursing Home was found not in compliance with the following requirements: F600 and F609. On 10/25/23 at 4:10 p.m., immediate jeopardy was identified relating to alleged sexual abuse and persistent psychological symptoms at F600, and failure to report alleged violations at F609. The survey team exited the building at 4:30 p.m. On 10/26/23 at 2:15 p.m., administrator A provided a plan for removal of the immediate jeopardy for F609. At 4:09 p.m., administrator A provided a plan for removal of the immediate jeopardy for F600. On 10/30/23 from 10:20 a.m. to 11:30 a.m., the survey team reviewed the provider's documentation for removal of the immediate jeopardies. Immediacy was removed at 11:30 a.m. The resident census was 43.	F 000		
F 600 SS=J	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	F 600	The Administrator, Director of Nursing (DON), and interdisciplinary team in collaboration with the medical director to review, revise, create, as necessary, policy and procedure for a thorough event investigation, documentation, and reporting process to necessary authority per regulation, regardless of resident family preference. On 10/26/2023 at 1:00 Director of Social Services spoke with resident 8. When asked if she feels safe and secure, resident responded with 'I think so'. When asked if she feels like it is a welcoming and friendly environment here, she	11/22/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lindsey Hauger
TITLE: Administrator
(X6) DATE: 11/22/2023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SD DOH-OLC

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 11/14/2023
FORM APPROVED
OMB NO. 0938-0391

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F 600

Continued From page 1

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:

A. Based on observation, interview, record review, and policy review, the provider failed to ensure one of one resident (8) had received the necessary care to meet her psycho-social needs after she made an allegation of sexual assault by resident (28).

Findings include:

1. Observation and interview on 10/24/23 at 10:25 a.m. with resident 8 about her experience in the nursing home revealed:

*She alleged that she was raped at that facility and the perpetrator "did not complete."

*There was a laceration on her left shin and foot that she said she acquired from the alleged perpetrator being on top of her trying to "get leverage."

*She was able to remember the alleged perpetrator's name and said he was another resident at the nursing home.

-That resident was now in a different part of the facility.

*She remembered she had informed someone about the incident, but she could not remember who she had told.

*When the incident happened, she had been in her chair asleep. She woke up and saw the alleged perpetrator in her bed. The next thing she knew, she was on the floor.

F 600 (Plan of Correction)

responded with yes. When asked if she would have a loved one needing care like here, how likely would you be to recommend, and the resident answered with 4 (on a scale of 1-5 with 5 being the highest). SS also reassessed resident using the Trauma Screen on 10/26/2023.SS Director asked Resident 8 if she would like to speak more to someone, like a counselor, about her experiences and how they are affecting her and she said, 'no.' Social Services Director clarified that she is currently seeing a counselor and resident had no recollection of the fact that she does currently meet with two counselors regularly and are aware of this incident. Counselors have included in their visit notes from 7/28/2023 and 7/31/2023. Resident continues with counseling services.Referral sent to Sanford Psychiatry and Psychology for outpatient services. Resident 8 has pertinent diagnosis of delusional disorders, Alzheimer's disease, Parkinson's disease, and depression. Resident 8 has had previous inpatient psychiatric stays at Avera Behavioral Health. SSD/designee will meet with resident 8 2 x's/week for 4 weeks to allow resident to share concerns/feelings and to evaluate her psychosocial wellbeing. Resident 8s scrape to her leg was first documented on 06/19/2023, 8 days prior to this incident. Resident's MD notified 10/26/2023 and assessed her 10/26/2023 to advise for further medical needs including psychosocial. Resident 8 offered interventions to deter uninvited residents from entering her room. i.e. velcro stop sign, motion sensor in doorway, etc.

A thorough investigation for this allegation began immediately when LTC management was made aware on 7/17/2023. Law enforcement was notified 10/26/2023 and the State Department of Health Report was filed on 10/26/2023. Abuse allegations will be reviewed daily for appropriate reporting.

Residents 19 and 20 have had separate private rooms since 7/23/2022. Resident 20 has voiced wanting to continue to have her husband, Resident 19, visit her in her room; family in agreement as well. On 11/21/2023, Social Services Director visited with Resident 20 to review psychosocial wellbeing and feelings of safety in the facility. Resident 20 states she feels safe in the facility. She expressed no

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F 600	Continued From page 2 *She said that several staff had known about her claims, but nothing was done to address them. *She expressed that she feared the males that would walk by her room. Interview on 10/24/23 at 11:08 a.m. with certified nursing assistant (CNA) Q about the above incident revealed: *Resident 8 "liked to talk and make accusations." *The alleged perpetrator had since been moved to a different part of the facility due to the accusations. Interview on 10/24/23 at 11:15 a.m. with licensed practical nurse (LPN) R about the above incident revealed: *She was aware of resident 8's allegations. *The incident happened on 6/27/23 at around 3:10 a.m. *She had been working at the facility on the night that the alleged rape happened. -She confirmed that resident 8 was found on the floor in front of her recliner and the alleged perpetrator was found asleep in resident 8's bed. *Resident 8's family was aware of the allegations. -LPN R explained that resident 8's family requested that staff inform her that the incident was "being taken care of through the court system." -The incident was not actually in the court system. -She and the other staff members did comply with the family's request. *Resident 8 would frequently ask staff what the status of her case was in the court system. Interview on 10/24/23 at 11:22 a.m. with director of social services (DSS) D about the above incident revealed: *The alleged perpetrator was known to wander	F 600	concern related to staff or other residents. SW specifically inquired about feelings of safety during visits with her spouse. Resident 20 states she feels safe around her spouse. She is comfortable with private visits and prefers to have visits with him in her room. She declined the need for visits to be held in public settings. Resident 20 offered counseling services. SSD/designee will meet with resident 20 1 x/week for 4 weeks to evaluate her wellbeing. Interviewable nursing home residents were interviewed in July and asked if they felt safe and secure and 100% answered yes. On the morning of 10/26, interviewable residents were interviewed individually and asked if they felt safe and secure and 100% answered yes. A directed in-service training was held on 10/26/2023 for all LTC staff of nursing, social services, activities, dietary, housekeeping, laundry, maintenance, and therapy on the following: The Abuse Prevention Plan Policy including physical abuse, sexual abuse, psychosocial abuse, neglect, involuntary seclusion, exploitation, misappropriation of a resident's property, an attempt to commit a crime against a patient, physical harm or injury, profanity, and deprivation of goods or services. The responsibility of every employee to report a suspicion or allegation of abuse to LTC management immediately regardless of if it is substantiated in their view. Staff not available on 10/26/2023 were tracked and additional training occurred, or a paper education provided with a sign off and quiz. A directed in-service was held on 10/26/2023 from Good Samaritan Society Regional Clinical Services Director and Accreditation Specialist Consultant to educate appropriate managers, including the administrator, Director of Nursing, Director of Social Services, and Risk Officer, regarding the abuse prevention policy, types of abuse, reporting any allegation of abuse, and timely reporting to SD DOH. Long Term Care Management will conduct 10 random staff interviews weekly for 4 weeks and then monthly for 3 months to determine understanding of our abuse policy.Long Term Care Management will conduct Abuse policy quizzes for staff competencies and/or abuse and neglect drills weekly for 4 weeks and then monthly for 3 months.	

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F 600	Continued From page 3 about the facility, and into other resident's rooms. *On 6/27/23, the male resident was found in resident 8's bed. *She explained that resident 8 usually slept in her recliner. *On that night, she woke up and saw a man in her bed; she thought that man was her deceased husband. *She got up from her recliner and fell. *DSS D confirmed that resident 8 did have a scratch and a scar on her foot. -She believed the scratch happened when resident 8 fell. *Since the resident's statements were inconsistent, and due to their internal investigation not finding evidence that a sexual assault had taken place, the management team did not contact the police or file a report with the South Dakota Department of Health (SD DOH). *She confirmed that since the incident, resident 8 was apprehensive of other people walking up and down the hallways. *Resident 8 had not made any allegations of rape until 7/14/23. -Social services had not been informed of the allegations until 7/17/23. -She confirmed that there was at least one nurse who had known about resident 8's allegations and had not reported those allegations to anyone. -It was her expectation that any allegation such as rape should have been reported right away to the management staff. It was up to the management staff to then report appropriate incidents to the SD DOH and law enforcement. *She confirmed that: -The alleged perpetrator was moved to a different part of the facility on 7/6/23. -Resident 8 had not been evaluated by a physician or mental health practitioner in	F 600	Findings will be taken to QAPI monthly for review and revision as warranted. The Administrator will be responsible for the completion of the Plan of Correction.	

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F 600	Continued From page 4	F 600		

reference to her alleged sexual assault.

2. Review of resident 8's Minimum Data Set (MDS) assessments revealed:
*On the 5/6/23 annual MDS assessment, she had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment.
*On the 7/29/23 quarterly MDS assessment, she had a BIMS score of 12, indicating moderate cognitive impairment.
*She had pertinent diagnoses of Alzheimer's disease, Parkinson's disease, and depression.

Review of a nurse's progress note on 7/14/23 at 11:14 p.m. revealed:
*"Resident upset this evening, concerned regarding man that lives down the hall from her as he stops to rest and looks in her room. Resident states that she needs to know where he is as she can't sleep if he is on the prowl. Provided reassurance that the gentleman has went [sic] to bed and he just goes up and down the hall and has not entered another [resident's] room. Resident asked nurse if nurse would take away the gentleman's w/c [wheelchair] so she can be assured to rest. Reassured resident that she was safe and that she did not need to worry. Resident then states 'well I thought I was safe before until that other man almost raped me.' Provided reassurance again that she was safe and that staff are here if she needs us."
-That nurse had not reported the resident's comment of an alleged attempted rape.
-The alleged rape was not reported until 7/17/23, when social services had received the report from an unidentified nurse.

3. IMMEDIATE JEOPARDY PSYCHOSOCIAL HARM

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Interviews with resident 8 and a review of her electronic medical record (EMR) showed continued signs of agitation and elevated emotional distress. She continued to believe the alleged rape was litigated through the court system. There was no police report. There was no report to the SD DOH. She had not been assessed physically or mentally regarding this incident.

IMMEDIATE JEOPARDY NOTICE
Notice of immediate jeopardy was given verbally and in writing on 10/25/23 at 4:10 p.m. to administrator A and director of nursing (DON) B. They were asked for an immediate removal plan.

IMMEDIATE JEOPARDY REMOVAL PLAN
On 10/26/23 at 4:09 p.m., administrator A provided the survey team with a final written immediate jeopardy removal plan. The removal plan had been approved by the survey team 10/26/23 at 4:17 p.m. with guidance from the long-term care advisor for the SD DOH.

The provider gave the following acceptable immediate jeopardy removal plan on 10/26/23 at 4:09 p.m.:
*"Pioneer Memorial personnel contacted the Viborg City Chief Police at 10:38 am on 10/26/2023 and are awaiting a reply. The State Department of Health Report was filed at 11:40 am on 10/26/2023.
On 10/26/2023 at 1:00 Director of Social Services spoke with [resident 8]. When asked if she feels safe and secure, resident responded with 'I think so'. When asked if she feels like it is a welcoming and friendly environment here, she responded with yes. When asked if she would have a loved one needing care like here, how likely would you

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F 600	Continued From page 6 be to recommend, and the resident answered with 4 (on a scale of 1-5 with 5 being the highest). SS [social services] also reassessed resident using the Trauma Screen on 10/26/2023. SS Director asked [resident 8] if she would like to speak more to someone, like a counselor, about her experiences and how they are affecting her and she said, 'no.' Social Services Director clarified that she is currently seeing a counselor and resident had no recollection of the fact that she does currently meet with two counselors regularly and are aware of this incident. Counselors have included in their visit notes from 7/28/2023 and 7/31/2023. SSD/designee will meet with [resident 8] 2 x's/week for 4 weeks to allow resident to share concerns/feelings and to evaluate her psychosocial wellbeing. Resident's MD [medical doctor] notified 10/26/2023 and assessing her 10/26/2023 to advise for further medical needs. [Resident 8] will be offered interventions to deter uninvited residents from entering her room. i.e. Velcro stop sign, Motion sensor in doorway, etc. Interviewable nursing home residents were interviewed in July and asked if they felt safe and secure and 100% answered yes. On the morning of 10/26, Interviewable residents were interviewed individually and asked if they felt safe and secure and 100% answered yes. On 10/26 at 9:30 am LTC management received training from Good Samaritan Society Regional Clinical Services Director and Accreditation Specialist Consultant regarding the abuse prevention policy, types of abuse, reporting any allegation of abuse, and timely reporting to SD DOH. On 10/26/2023 at 2:00 all available LTC staff of nursing, social services, activities, dietary, housekeeping, laundry, maintenance, and	F 600		

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F 600	Continued From page 7	F 600		

therapy will receive education on the following: The Abuse Prevention Plan Policy including physical abuse, sexual abuse, psychosocial abuse, neglect, involuntary seclusion, exploitation, misappropriation of a resident's property, an attempt to commit a crime against a patient, physical harm or injury, profanity, and deprivation of goods or services. The responsibility of every employee to report a suspicion or allegation of abuse to LTC management immediately regardless of it is substantiated in their view. Social Services Director provided specific examples of sexual, financial, physical, and verbal abuse while maintaining HIPAA [Health Insurance Portability and Accountability Act] protocols during the educational meeting. Staff not available on 10/26/2023 will be tracked and additional trainings will occur, or a paper education will be provided with a sign off and quiz.
Long Term Care Management will conduct 10 random staff interviews weekly for 4 weeks and then monthly for 3 months to determine understanding of our abuse policy.
Long Term Care Management will conduct Abuse policy quizzes for staff competencies and/or abuse and neglect drills weekly for 4 weeks and then monthly for 3 months.
Findings will be taken to QAPI monthly for review and revision as warranted."

The immediate jeopardy was removed on 10/30/23 at 11:30 a.m. after verification that the provider had implemented their removal plan. After the removal of the immediate jeopardy, the scope and severity of the citation level was "G."

4. Interview on 10/31/25 at 11:15 a.m. with DON B revealed:

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F 600	Continued From page 8	F 600		

*That looking back she now knows that the incident should have been reported to both law enforcement and the SD DOH.
*That her expectation was that all required incidents should have been reported to the proper authorities.

Interview on 10/31/25 at 1:30 p.m. with administrator A revealed that her expectation was that the incident between both residents 8 and 28 should have been reported to both law enforcement and SD DOH when they occurred.

5. Review of a nurse's psychotropic drug review note on 10/3/23 revealed resident 8 "continues to talk about rape charge and scrape on her leg."

B. Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (20) had been protected from verbal and physical abuse by her husband, resident (19) while both resided in the facility.
Findings include:

1. Observation and interview on 10/24/23 at 2:05 p.m. with resident 20 about her experience in the nursing home revealed:
*She had been in her chair since 9:00 a.m.
*She said she had had a stroke two years ago and could not move her right side.

2. Review of resident 20's EMR revealed:
*Resident 19 was her husband and she had shared a room with him.
*On 9/21/23 resident 19 had struck her on the right arm causing pain to her.
*The incident was not reported to staff until 9/28/23 by their daughter.

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*Resident 20 stated that she felt safe and did not want her husband taken away.
*The provider contacted law enforcement and reported the incident to the SD DOH.

3. Interview on 10/25/23 at 11:40 a.m. with resident 20's daughter revealed:
*She was told by resident 20 that resident 19 had hit her and that it had hurt.
*Resident 19 became angry at resident 20 due to him believing that resident 20 had a romantic relationship with another resident prior to their marriage, which led to resident 19 hitting resident 20.
*The daughter explained that resident 19 had never hit resident 20 before.
*When asked to repeat and clarify the incident, the daughter denied the incident and said it was an accident.
*She explained that resident 20 would have defended resident 19, no matter what.

Interview on 10/31/23 at 9:33 a.m. with resident 20 revealed when she was asked about resident 19 hitting her that she denied that he hurt her and that he only "tapped" her.

Interview on 10/25/23 at 12:00 p.m. LPN R revealed:
*Both residents 19 and 20 should have spent time together in public spaces.
*If both residents 19 and 20 were in a room alone, the door should have stayed open.
*If an incident occurred between residents 19 and 20, it should have been notated in resident 19's behavior log.
*No incident had been recorded sine that last incident.

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F 600	Continued From page 10 4. Review of resident 19's behavior logs on 10/31/23 at 1:38 p.m. revealed that on 10/28/23 resident 19 was seen yelling at resident 20 about him not being able to watch the football game. He was redirected and was fine after this incident. 5. Interview on 10/31/23 at 11:27 a.m. with DSS D revealed: *The incident was reported by both resident 19 and 20's daughter on 9/28/23. *Resident 19 was moved from their joint room to a private room down the hall and around the corner from resident 20's room. *Resident 20 did not voice any safety concerns with having her husband in the facility. *Resident 20 later said that resident 19 did not hit her and that it was an accident. Interview on 10/31/23 at 1:28 p.m. with administrator A revealed after the incident was reported to a staff member, a report had been filed with SD DOH and law enforcement was notified. 6. Review of the provider's 10/20/22 "Abuse Prevention Plan" policy revealed: *Under the "Definitions" section: -"C. Sexual Abuse includes, but is not limited to, sexual harassment, sexual coercion, sexual assault, or inappropriate touch. Sexual abuse is nonconsensual sexual contact of any type with a resident." -"E. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress." *Under the "Responsibility" section: -"A. It is the responsibility of every employee to:	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435120	A. BUILDING ______ B. WING ______	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL NURSING HOME	315 NORTH WASHINGTON ST VIBORG, SD 57070

(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 600	Continued From page 11 --"2. If the crime does not appear to cause serious bodily harm, report directly to the DOH and local law enforcement agency or to his/her department director who will document the information and initiate the investigation." -"B. It is the responsibility of the Director of Nursing (DON) of Long Term Care Services or designee or the DON of the Hospital or designee to:" --"1. Monitor incident reports to identify residents who are repeatedly injured or involved in incidents to identify a trend." --"2. Notify the family of the allegation of neglect or abuse of the resident." --"3. Report to the DOH [email redacted] on-line reporting form or fax to [fax number redacted] ombudsman [ombudsman phone number redacted] and local law enforcement [phone numbers redacted] if not already reported by an individual, any allegation of mistreatment, neglect, or abuse within the required time frame of the alleged mistreatment, neglect, or abuse." --"4. Submit REQUIRED NURSING FACILITY EVENT REPORT (on line) to DOH Complaint Coordinator per instructions of form." --"5. Investigate reported allegations of mistreatment, neglect, or abuse and file the results of the investigation with DOH within five (5) working days on 5- DAY INVESTIGATIVE REPORT (on-line)." *Under the "Policy" section: -"A. PMH&HS [Pioneer Memorial Hospital and Health Services] will ensure the resident's right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion by anyone, including but not limited to staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members, friends or other individuals."	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435120	A. BUILDING ______ B. WING ______	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL NURSING HOME	315 NORTH WASHINGTON ST VIBORG, SD 57070

(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 600	Continued From page 12 -"C. ...3. According to South Dakota Administrative Rules, 44:73:01:07, PMH&HS shall also report to the (DOH) within 24 hours and any other licensed facility shall report to the DOH within 48 hours of the event using REQUIRED NURSING FACILITY EVENT REPORTING form on-line ... Any allegation of abuse or neglect of any patient by any person."	F 600		
F 609 SS=J	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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	F 609	The Administrator, Director of Nursing (DON), and interdisciplinary team in collaboration with the medical director to review, revise, create, as necessary, policy and procedure for a thorough event investigation, documentation, and reporting process to necessary authority per regulation, regardless of resident family preference. A directed in-service training was held on 10/26/2023 for all LTC staff of nursing, social services, activities, dietary, housekeeping, laundry, maintenance, and therapy on the following: The Abuse Prevention Plan Policy including physical abuse, sexual abuse, psychosocial abuse, neglect, involuntary seclusion, exploitation, misappropriation of a resident's property, an attempt to commit a crime against a patient, physical harm or injury, profanity, and deprivation of goods or services. The responsibility of every employee to report any suspicion or allegation of abuse to LTC management immediately regardless of if it is substantiated in their view. Staff not available on 10/26/2023 were tracked and additional training occurred, or a paper education provided with a sign off and quiz. A directed in-service was held on 10/26/2023 from Good Samaritan Society Regional Clinical Services Director and Accreditation Specialist Consultant to educate appropriate managers, including the administrator, Director of Nursing, Director of Social Services, and Risk Officer, regarding the abuse prevention policy, types of abuse, reporting any allegation of abuse, and timely reporting to SD DOH. Law enforcement was notified 10/26/2023 and the State Department of Health Report was filed on 10/26/2023. Abuse allegations will be reviewed daily for appropriate reporting. All incident reports will be audited by the administrator or designee weekly for 4 weeks, then biweekly x's 2, then monthly x's 2. Findings will be taken to QAPI monthly for review and revision as warranted. The Administrator will be responsible for the completion of the Plan of Correction.	11/22/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435120	A. BUILDING ______ B. WING ______	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL NURSING HOME	**315 NORTH WASHINGTON ST** **VIBORG, SD 57070**

(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 609	Continued From page 13 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure an allegation of sexual assault made by resident (8) toward resident (28) was thoroughly investigated and reported to the South Dakota Department of Health (SD DOH). Findings include: 1. Observation and interview on 10/24/23 at 10:25 a.m. with resident 8 about her experience in the nursing home revealed: *She alleged that she was raped at that facility and the perpetrator "did not complete." *There was a laceration on her left shin and foot that she said she acquired from the alleged perpetrator being on top of her trying to "get leverage." *She was able to remember the alleged perpetrator's name and said he was another resident at the nursing home. -That resident was now in a different part of the facility. *She remembered she had informed someone about the incident, but she could not remember who she had told. *When the incident happened, she had been in her chair asleep. She woke up and saw the alleged perpetrator in her bed. The next thing she knew, she was on the floor. *She said that several staff had known about her claims, but nothing was done to address them. *She expressed that she feared the males that would walk by her room. Interview on 10/24/23 at 11:22 a.m. with director of social services (DSS) D about the above	F 609		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435120	A. BUILDING ______ B. WING ______	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL NURSING HOME	315 NORTH WASHINGTON ST VIBORG, SD 57070

(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 609	Continued From page 14 incident revealed: *The alleged perpetrator was known to wander about the facility, and into other resident's rooms. *On 6/27/23, the male resident was found in resident 8's bed. *She explained that resident 8 usually slept in her recliner. *On that night, she woke up and saw a man in her bed; she thought that man was her deceased husband. *She got up from her recliner and fell. *DSS D confirmed that resident 8 did have a scratch on her foot. -She believed the scratch happened when resident 8 fell. *Since the resident's statements were inconsistent, and due to an internal investigation not finding evidence that a sexual assault had taken place, the management team did not contact the police or file a report with the SD DOH. -They "did not feel it escalated to that level to report [the alleged rape]." *She confirmed that since the incident, resident 8 was apprehensive of other people walking up and down the hallways. *Resident 8 had not made any allegations of rape until a couple of weeks after 6/27/23. -She mentioned there was a progress note on 7/14/23 written by a nurse that mentioned the alleged rape. -Social services had not been informed of the allegations until 7/17/23. -She confirmed that there was at least one nurse who had known about resident 8's allegations and had not reported those allegations to anyone. -It was her expectation that any allegation such as rape should have been reported right away. *She confirmed that the alleged perpetrator was	F 609		

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	435120	A. BUILDING ___ B. WING ___	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL NURSING HOME	315 NORTH WASHINGTON ST VIBORG, SD 57070

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F 609	Continued From page 15	F 609		

moved to a different part of the facility on 7/6/23.

2. Record review of resident 8's electronic medical record (EMR) revealed:
*There was a nurse's psychotropic drug review note on 10/3/23 which indicated resident 8 "continues to talk about rape charge and scrape on her leg."
*The 5/6/23 annual Minimum Data Set (MDS) assessment, her Brief Interview for Mental Status (BIMS) score was 11, which indicated moderate cognitive impairment.
*The 7/29/23 quarterly MDS assessment, her BIMS score was 12, which indicated moderate cognitive impairment.
*She had diagnoses of Alzheimer's disease, Parkinson's disease, and depression.

Email communication with the SD DOH Complaint department on 10/24/23 at 10:54 a.m. confirmed there was no report submitted regarding the alleged rape.

3. IMMEDIATE JEOPARDY PSYCHOSOCIAL HARM
Interviews with resident 8 and a review of her EMR showed continued signs of agitation and elevated emotional distress. She continued to believe the alleged rape was litigated through the court system. There was no police report. There was no report to the SD DOH. She had not been assessed physically or mentally regarding this incident.

IMMEDIATE JEOPARDY NOTICE
Notice of immediate jeopardy was given verbally and in writing on 10/25/23 at 4:10 p.m. to administrator A and director of nursing (DON) B. They were asked for an immediate removal plan.

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	435120	A. BUILDING ______ B. WING ______	10/31/2023

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PIONEER MEMORIAL NURSING HOME	315 NORTH WASHINGTON ST VIBORG, SD 57070

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F 609	Continued From page 16	F 609		

IMMEDIATE JEOPARDY REMOVAL PLAN
On 10/26/23 at 2:15 p.m., administrator A provided the survey team with a final written immediate jeopardy removal plan. The removal plan had been approved by the long-term care advisor for the SD DOH on 10/26/23 at 2:26 p.m.

The provider gave the following acceptable immediate jeopardy removal plan on 10/26/23 at 2:15 p.m.:
"Pioneer Memorial personnel contacted the Viborg City Chief Police at 10:38 am on 10/26/2023 and are awaiting a reply. The State Department of Health Report was filed at 11:40 am on 10/26/2023.
On 10/26/2023 all internal investigative events were audited for accuracy in reporting to SD DOH from 6/1/2023 [to] current.
On 10/26 at 9:30 am LTC [Long-Term Care] Management including the administrator, Director of Nursing, Director of Social Services, and Risk Officer received training from Good Samaritan Society Regional Clinical Services Director and Accreditation Specialist Consultant regarding the abuse prevention policy, types of abuse, reporting any allegation of abuse, and timely reporting to SD DOH.
On 10/26/2023 at 2:00 [p.m.] all available LTC staff of nursing, social services, activities, dietary, housekeeping, laundry, maintenance, and therapy received education on the following: The Abuse Prevention Plan Policy including physical abuse, sexual abuse, psychosocial abuse, neglect, involuntary seclusion, exploitation, misappropriation of a resident's property, an attempt to commit a crime against a patient, physical harm or injury, profanity, and deprivation of goods or services. The responsibility of every

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	435120	A. BUILDING ______ B. WING ______	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL NURSING HOME	315 NORTH WASHINGTON ST VIBORG, SD 57070

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F 609	Continued From page 17	F 609		

employee to report a suspicion or allegation of abuse to LTC management immediately regardless of it is substantiated in their view. Staff not available on 10/26/2023 will be tracked and additional trainings will occur, or a paper education will be provided with a sign off and quiz. Abuse allegations will be reviewed daily for appropriate reporting.
All incident reports will be audited by the administrator weekly for 4 weeks, then biweekly x's 2, then monthly x's 2. Findings will be taken to QAPI [Quality Assurance and Performance Improvement] monthly for review and revision as warranted."

The immediate jeopardy was removed on 10/30/23 at 11:30 a.m. after verification that the provider had implemented their removal plan. After the removal of the immediate jeopardy, the scope and severity of the citation level was "G."

4. Review of the provider's 10/20/22 "Abuse Prevention Plan" policy revealed:
*Under the "Definitions" section:
-"C. Sexual Abuse includes, but is not limited to, sexual harassment, sexual coercion, sexual assault, or inappropriate touch. Sexual abuse is nonconsensual sexual contact of any type with a resident."
-"E. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress."
*Under the "Responsibility" section:
-"A. It is the responsibility of every employee to:
--"2. If the crime does not appear to cause serious bodily harm, report directly to the DOH and local law enforcement agency or to his/her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435120	A. BUILDING ______ B. WING ______	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL NURSING HOME	315 NORTH WASHINGTON ST VIBORG, SD 57070

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F 609	Continued From page 18	F 609		

department director who will document the information and initiate the investigation."
-"B. It is the responsibility of the Director of Nursing (DON) of Long Term Care Services or designee or the DON of the Hospital or designee to:"
--"1. Monitor incident reports to identify residents who are repeatedly injured or involved in incidents to identify a trend."
--"2. Notify the family of the allegation of neglect or abuse of the resident."
--"3. Report to the DOH [email redacted] on-line reporting form or fax to [fax number redacted] ombudsman [ombudsman phone number redacted] and local law enforcement [phone numbers redacted] if not already reported by an individual, any allegation of mistreatment, neglect, or abuse within the required time frame of the alleged mistreatment, neglect, or abuse."
--"4. Submit REQUIRED NURSING FACILITY EVENT REPORT (on line) to DOH Complaint Coordinator per instructions of form."
--"5. Investigate reported allegations of mistreatment, neglect, or abuse and file the results of the investigation with DOH within five (5) working days on 5- DAY INVESTIGATIVE REPORT (on-line)."
*Under the "Policy" section:
-"A. PMH&HS [Pioneer Memorial Hospital and Health Services] will ensure the resident's right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion by anyone, including but not limited to staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members, friends or other individuals."
-"C. ...3. According to South Dakota Administrative Rules, 44:73:01:07, PMH&HS shall also report to the (DOH) within 24 hours and

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL NURSING HOME	**315 NORTH WASHINGTON ST** **VIBORG, SD 57070**

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F 609	Continued From page 19 any other licensed facility shall report to the DOH within 48 hours of the event using REQUIRED NURSING FACILITY EVENT REPORTING form on-line ... Any allegation of abuse or neglect of any patient by any person."	F 609		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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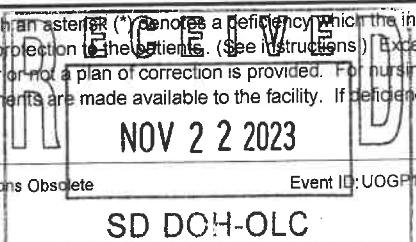
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 10/24/23 through 10/25/23, and from 10/30/23 through 10/31/23. Pioneer Memorial Nursing Home was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lindsey Hauger	Administrator	11/16/2023

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.



PRINTED: 11/14/2023
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435120	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**10/24/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL NURSING HOME	**315 NORTH WASHINGTON ST** **VIBORG, SD 57070**

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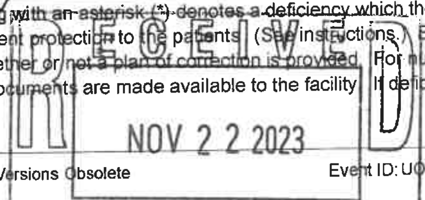
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/24/23. Pioneer Memorial Nursing Home was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lindsey Hauger | TITLE: Administrator | (X6) DATE: 11/16/2023

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.



PRINTED: 11/14/2023
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10698	A. BUILDING: ______ B. WING ______	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL NURSING HOME	315 N WASHINGTON ST VIBORG, SD 57070

(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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/24/23 through 10/25/23, and from 10/30/23 through 10/31/23. Pioneer Memorial Nursing Home was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 10/24/23 through 10/25/23, and from 10/30/23 through 10/31/23. Pioneer Memorial Nursing Home was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lindsey Hauger

TITLE: Administrator

(X6) DATE: 11/16/2023