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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spearfish Canyon Healthcare	1020 N 10th Street Spearfish, SD 57783

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.*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 (EMR) revealed:*She was admitted on [DATE].* 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. 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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. *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: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-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 [DATE] 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 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*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, 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 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-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.” 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*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 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 [DATE] 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 [DATE] 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	* 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. [NAME] 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 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-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. *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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	*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. *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. (continued on next page)

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spearfish Canyon Healthcare	1020 N 10th Street Spearfish, SD 57783

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	*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 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-She stated the policy had stated before, that staff were to use gait belts with “anyone” who ambulated or 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. -How to report suspected or actual abuse. -Incident Reporting. *CNA O received re-education on 4/9/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-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.”