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	04/20/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **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, observation, and interview, the provider failed to ensure one of one sampled resident (1) remained free from verbal abuse by one of one certified nurse aide (CNA) D.Findings include:1. Review of the provider's 9/16/25 submitted SD DOH FRI report regarding resident 1 revealed that at 6:30 a.m. on 9/16/25, CNA C and CNA D were conducting walking rounds (a process where outgoing and oncoming staff complete a handoff report regarding resident care information at each resident's bedside) on the 400 Hall. Resident 1 exited her room and asked for assistance. CNA D replied to resident 1, I don't have time for your [expletive word]. CNA C intervened by assisting resident 1 back into her room, and then directed CNA D to exit the facility. CNA C reported the incident to director of nursing (DON) B that same day at 8:30 a.m.DON B suspended CNA D from working on 9/16/25 pending the outcome of the facility's investigation of the above incident. She interviewed other staff members who were near CNA C, CNA D, and resident 1 on 9/16/25, when the incident occurred. Those staff members confirmed hearing the above verbal interaction by CNA D to resident 1. DON B ensured that the resident's medical provider and her power of attorney (someone designated on a legal document to act on behalf of a resident) were notified of the incident.2. Review of resident 1's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. Her diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) with behavioral disturbances and anxiety (anticipation of future changes or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). Her 9/17/25 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated her cognition was moderately impaired. On 1/9/26, resident 1 transitioned to hospice services.3. Observation on 4/20/26 at 10:15 a.m. of resident 1 revealed she was asleep in her bed and unable to be interviewed. 4. Review of CNA D's personnel file revealed she was hired at the facility on 6/25/25. On that same date, she completed education on resident abuse and neglect reporting, residents' rights, and the provider's grievance policy and procedure. She signed off on her understanding of the provider's abuse policy on 6/28/25. CNA D's CNA certification was current, and there were no known disciplinary actions associated with that certification. Her background check was completed on 6/18/25 and had no remarkable findings.5. The provider's implemented actions to mitigate the likelihood of the deficient practice from reoccurring were verified on 4/20/26 after record review, and interview with administrator A and DON B revealed that the facility had followed its quality assurance (QAPI) process regarding verbal abuse towards residents by interviewing resident 1 on 9/16/25 regarding the above incident. Resident 1 voiced no concerns regarding her care. Her psycho-social well-being was assessed and determined to be at baseline according to DON B. They monitored and documented resident 1's behavior and her psycho-social well-being following the incident. They ensured resident 1's care plan was reviewed and updated related to her impaired cognition and her history of behavioral concerns. Changes to resident 1's mood-altering medications were monitored, and her medical provider was kept informed of any resulting changes in resident 1's physical and mental health. Resident 1's family and (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
	435043	A. Building B. Wing	04/20/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	power-of-attorney participated in care plan meetings and were informed of pertinent changes in the resident's physical and mental health.In addition, a sample of residents were interviewed between 9/17/25 and 9/18/25 regarding any care concerns they had, how staff interacted with them, and their feelings of safety. No issues were identified. CNA D was terminated from employment on 9/22/25. All staff were educated (9/30/25) regarding the process of de-escalating residents with challenging behaviors. The incident was brought to the facility's Quality Assurance and Performance Improvement meeting for further review by that interdisciplinary team.Based on the above information, non-compliance at F600 occurred on 9/16/25, and based on the provider's corrective action plans that were initiated on 9/16/25 and implemented for the deficient practice confirmed on 4/20/26, the non-compliance is considered past non-compliance.