

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER Winner Regional Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8th St Winner, SD 57580	

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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) complaint report review, record review, and interview, the provider failed to ensure care plans were reviewed and revised to reflect the current care needs of two of two sampled residents (1 and 2):</p> <p>*One of one sampled resident (1) with verbally aggressive behaviors.</p> <p>*One of one sampled resident (2) vulnerable to verbal aggression from her roommate.</p> <p>Findings include:</p> <p>1. Review of the 1/28/25 SD DOH complaint report revealed a resident with dementia (1) was physically aggressive with staff.</p> <p>*He had an alarm placed.</p> <p>-The report did not identify where, why, or what type of alarm had been placed.</p> <p>*An anonymous staff member was afraid that the alarm would not prevent the resident from going after other residents and staff.</p> <p>Review of resident 1's medical record revealed:</p> <p>*He was admitted on [DATE].</p> <p>*His 4/7/25 Brief Interview of Mental Status (BIMS) assessment score was 1, which indicated he had severe cognitive impairment.</p> <p>*His diagnoses included: dementia, psychotic disturbance, mood disturbance, and anxiety.</p> <p>*His nurse progress notes indicated:</p> <p>-On 3/29/25, Resident was yelling at his [roommate].</p> <p>(continued on next page)</p>

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: 435056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER Winner Regional Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8th St Winner, SD 57580	

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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 5/16/25 at 12:45 p.m., resident 1, while in his room, was cussing and yelling at a staff member. His roommate asked him to please stop cussing and allow staff to help him. Resident 1 told his roommate, Shut the hell up or I will slap .</p> <p>-On 5/16/25 at 6:11 p.m., resident 1 was very agitated, and he cussed at his roommate.</p> <p>*His current care plan reviewed on 5/20/25 did not include that:</p> <p>-He was verbally aggressive to his roommate or to staff.</p> <p>-He had any aggressive behaviors, or interventions for staff to implement to address his behaviors.</p> <p>2. Review of resident 2's medical record revealed:</p> <p>*She was admitted on [DATE].</p> <p>*Her 4/7/25 BIMS assessment score was a 13, which indicated her cognition was intact.</p> <p>*Her diagnoses did not include any mental health diagnoses.</p> <p>*Her nurse progress notes indicated that on 4/14/25 her roommate had been observed to holler at her on occasion. Her family was aware and had chosen not to move her to another room.</p> <p>*Her current care plan, reviewed on 5/20/25, did not include that she was vulnerable to verbal aggression by her roommate or any interventions for staff to implement to address or limit that vulnerability.</p> <p>3. Interview on 5/20/25 at 4:30 p.m. with director of social services (DSS) C revealed:</p> <p>*The facility utilized a contracted service to complete the Minimum Data Set (MDS) assessment (used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) while a new MDS coordinator was being trained.</p> <p>*She confirmed that resident 1's care plan did not include his aggressive behaviors or interventions to address those behaviors.</p> <p>*She confirmed that resident 2's care plan did not include her vulnerability to verbal aggression from her roommate or any interventions to address that vulnerability.</p> <p>*She would absolutely expect to see those issues identified in resident 1 and resident 2's care plans.</p> <p>*She stated the care plans were not revised due to a lapse between me and the MDS nurse.</p> <p>4. Interview on 5/21/25 at 11:33 a.m. with director of nursing (DON) B regarding care plans revealed:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER Winner Regional Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8th St Winner, SD 57580	

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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*She confirmed that resident 1's care plan did not reflect his aggressive behaviors.</p> <p>*She confirmed that resident 2's care plan did not address her vulnerability to verbal aggression from her roommate.</p> <p>*She stated that she and the MDS nurse shared responsibility for those care plans not having been revised to reflect residents' current care needs.</p> <p>*She agreed that care plans should reflect the residents' current needs and interventions to address those needs.</p>