STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winner Regional Healthcare Center	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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview, observation, and policy review, the provider failed to make information available on how to file a grievance, ensure the grievance forms were readily available to residents and their representatives, designate who the grievance official was, and follow their grievance process when one of one sampled residents' (5) representative expressed a concern about an injury. Findings Include:1. Observation on 5/27/26 at 8:10 a.m. revealed there were no grievance forms or information on how to file a grievance located in the resident care areas, at the nurses' station, near the dining room, or in the activities room. 2. Interview on 5/27/26 at 8:16 a.m. with social services designee (SSD) F revealed she thought that the grievance official was either licensed social worker (LSW) E or chief executive officer (CEO) A. SSD F was responsible for filing the grievances in a binder. She had not assisted any resident or family member in completing a grievance form.There was no grievance, concern, or complaint filed by resident 5's family member regarding the 11/19/25 incident when resident 5 received a hot liquid burn injury 3. Observation and interview on 5/27/26 at 2:12 p.m. with LSW E revealed she was the grievance official until she began working remotely about two years ago. She supervised SSD F and worked at the facility two days per month. SSD F was the grievance official and was responsible for ensuring that the grievances were investigated by the appropriate department, that follow-up occurred with the individual filing the grievance, and that the grievance form was filed and retained for several years.LSW E expected the grievance forms to be located in each hallway where there were resident rooms, outside of the director of nursing (DON) B's office, and outside of the social services office.She confirmed there were no grievance forms located outside DON B's office or in the 300 hallway. The grievance binder in the 200 hallways was located inside a clear file holder that also held trash bags. It was approximately five feet from the floor and did not contain grievance forms. She agreed that residents who required the use of a wheelchair would not have access to those grievance forms. There were grievance forms in a binder near the front door of the facility outside of the social services office. She confirmed that it was not a resident care area and most residents would not have known they were there. She thought that residents could file a grievance anonymously by sliding a form under SSD F's door or by placing it in the box near the front door.LSW E expected that SSD F would have been responsible for handling a family member's concern if it was not a concern that was required to be reported to the South Dakota (SD) Department of Health (DOH). 4. Interview on 5/27/25 at 2:20 p.m. and again at 3:37 p.m. with LSW E and SSD F revealed SSD F read about resident 5's 11/19/25 hot liquid burn injury the following day (11/20/25) in the nurse's progress note. At that time, it was documented that resident 5 spilled her coffee in her lap. She could not recall when she learned that resident 5's daughter stated that she thought the hot liquid burn injury was caused by a staff member. She was unsure if a grievance form should have been completed or if that hot liquid burn injury should have been reported to the SD DOH.LSW E became aware of resident 5's family members' concern that resident 5 received a hot liquid burn injury and that resident 5's family member thought that a staff member caused that hot liquid burn injury on 12/23/25 when DON B called her several weeks after resident 5 received a hot liquid burn injury from her tea, because a family member complained to the dietitian that staff spilled coffee on (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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident 5.LSW E was unaware when resident 5's family member first shared the concern that the hot liquid injury was caused by a facility staff member.LSW E expected that if resident 5's family member shared a concern with any staff member that she thought that a staff member caused resident 5's hot liquid burn injury, that a grievance form would have been completed, and that concern would have been reported to CEO A and DON B immediately. 5. Resident Council group interview on 5/27/26 at 2:45 p.m. revealed that three residents attended. The three residents who attended did not know how to file a grievance or where the grievance forms were located. Resident 20 stated that if she had a concern or a grievance, she would tell a nurse and hoped that the nurse would fix the problem. 6. Phone interview on 5/27/26 at 4:34 p.m. with resident 5's family member regarding resident 5's 11/19/25 hot liquid burn injury revealed she visited resident 5 on 11/24/24 and was told by resident 5, they burned me, and resident 5 showed her the inner thigh area. She was resident 5's emergency contact, and no notification was provided to her or the other listed emergency contact. It had been about a week since that incident occurred. While at the facility on 11/24/25, she spoke with a nurse (she was unable to recall who she spoke with) about the incident and was told that the documentation in resident 5's EMR said that resident 5 spilled her own coffee in her lap and that the emergency contact was notified.She stated that resident 5 was coherent, repeated several times, they burned me, and that she believed resident 5. She told the nurse that she thought a staff member caused resident 5's hot liquid burn injury and that she was upset that she and the emergency contact were not notified. She expected someone to follow up with her about her concerns.Resident 5's family member attended the 12/9/24 care conference meeting and told the staff members, again, that she was concerned that a staff member caused resident 5's hot liquid burn injury, and that she and the other emergency contact were not notified. She recalled that registered dietitian (RD) H was present at that care conference and said she would check into it.On 11/23/25, she stopped to visit with RD H because she was not provided any additional information about what happened when resident 5 was burned or what the facility was doing about it.She was frustrated that the facility did not follow up with her about her concerns and stated that she hoped that an incident like this would not happen again or happen to anyone else. 7. Interview on 6/1/26 at 12:17 p.m. and again on 6/2/25 at 11:31 a.m. with DON B regarding resident 5's 11/19/25 hot liquid burn injury revealed that she was notified on 12/22/25 that resident 5's family member was stating that resident 5 was burned by hot liquid and that she thought that a staff member caused the hot liquid burn injury. She was not notified on 11/19/25 that resident 5 received a hot liquid burn injury, and did not expect to be notified because it was not serious enough to require a visit to the emergency room, and staff thought that she spilled her hot tea on herself.She expected the staff in attendance at resident 5's care conference on 12/9/25 to have completed a grievance form when they were notified by resident 5's family member that she was concerned that resident 5 was burned by a staff member with a hot liquid. If a grievance form was filled out, DON B would have been notified, she would have begun an investigation, and would have had the information to follow up with resident 5's family member after the investigation was completed. 8. Interview on 6/2/26 at 8:25 a.m. with RD H regarding resident 5's 11/19/25 hot liquid burn injury revealed she learned of the injury during resident 5's 12/9/25 care conference. She was unsure if a grievance form was completed when resident 5's family member voiced that she was concerned that resident 5 was burned by a staff member with a hot liquid. RD H expected that SSD F would have completed a grievance form if it was appropriate and followed up with resident 5's family after the 12/9/25 care conference. She was surprised when resident 5's daughter visited her again on 12/23/25 and was still concerned about resident 5's 11/19/25 hot liquid burn injury. 9. Interview on 6/2/26 at 9:48 a.m. with SSD F revealed that she attended resident 5's 12/9/25 care conference and was aware that resident 5's family member was concerned about how resident 5 was burned by her hot tea, but it was documented that resident 5 spilled her tea on herself. She was unsure if a grievance should have been completed. She felt that if resident 5's daughter voiced a concern to a nurse on 11/24/25 or to RD H, they would have completed a grievance form if it was appropriate. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing or dietary would have been responsible for completing an investigation into those concerns. She was unaware that resident 5's family member had more concerns about resident 5's hot liquid burn injury or how the burn injury happened. After resident 5's 12/9/25 care conference, SSD F expected RD H to have followed up with resident 5's family member about what interventions the facility implemented.Resident 5 spilled her own tea, so she did not think that there was anything else to follow up with the family about. 10. Review of the provider's reviewed December 2021 Filing Grievances/Complaint policy revealed Our facility will assist residents, their representatives (sponsors), other interested family members, or advocates in filing grievances or complaints when such requests are made. It did not identify who the grievance official was. 11. Review of the Provider's undated Grievance/Concern Follow-up form revealed This form should be completed on any resident comment or criticism not resolved immediately, regarding their care or treatment in any of our facilities. This may come in the form of a resident satisfaction survey, a letter, a phone call, or a conversation with a resident/family member/visitor, etc. 12. Review of the provider's undated Long-Term Care Center Resident Grievance/Concern Procedure revealed .all residents and/or his/her representative have the right to voice grievances/concerns to the facility. Grievance/Concerns can be filed orally or written on the facilities grievance/concern form. (Located in the Grievance/Concern folder outside the social services office or at the end of each wing [hallway]). We want to ensure prompt resolution of all grievances regarding the resident's rights.The grievance official was listed as LSW E. SSD F's contact information was not included in that procedure.

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F 0600 Level of Harm - 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 the South Dakota Department of Health (SD DOH) Facility Reported Incident (FRI), interview, record review, and policy review, the facility failed to protect one of one resident's (13) right to be free from physical abuse by contracted travel certified nursing assistant (CNA) BB who used physical force while providing care to resident 13 who subsequently had a skin tear and bruising to her arms. Findings include:1. Review of the provider's 2/25/26 SD DOH FRI revealed on 2/24/26, at around 6:00 a.m., an unidentified CNA entered resident 13's room to assist her with her morning care. The CNA noted that resident 13 had bruises on both her arms and a skin tear on her right arm. The CNA reported her findings to the on-duty contracted travel registered nurse (RN) T. The nurse assessed resident 13 and confirmed that she had bruises on both arms and a skin tear on her right arm. Resident 13 told the CNA and RN that a girl from the night shift was mean, grabbed her arm, and wanted her to get out of bed to go to the bathroom. Resident 13 told the staff member no and said she had already gone to the bathroom, but the staff member made her get up out of bed. The incident, along with resident 13's bruising and skin tear, was reported to director of nursing (DON) B when she arrived at work that same day. On the evening of 2/24/26, DON B and the chief executive officer (CEO) A met with contracted travel CNA BB, to discuss resident 13's abuse allegation. Contracted travel CNA BB explained that she was assisting resident 13 in getting ready for bed on the evening of 2/23/26. While helping resident 13 stand, resident 13 began to fall, contracted travel CNA BB grabbed resident 13 by both forearms to steady her, which may have caused the bruising. When contracted travel CNA BB went in to assist resident 13 with care early the next morning on 2/24/26, resident 13 was combative, but contracted travel CNA BB said she was able to reason with resident 13 and left her room when resident 13 told her to. Contracted travel CNA BB wrote a statement about the incident and was placed on administrative leave pending the investigation. CEO A and DON B interviewed resident 13 regarding her allegation following the meeting held with contracted travel CNA BB, and resident 13's account of the incident did not differ from her previous explanations. DON B said that a witness statement was obtained by the unidentified CNA, which documented the bruising and skin tear on resident 13's arms the morning of 2/24/26. The unidentified CNA's witness statement was provided by DON B for review and revealed that the unidentified CNA's findings were written on a sheet of paper that contained no date or signature and contained another witness statement from an unidentified staff member with no date or signature. The statement for the unidentified CNA explained the findings regarding resident 13's bruising and skin tear on the morning of 2/24/26, and the statement by an unidentified staff member explained resident 13's mood and behavior from the previous evening, 2/23/26. Law Enforcement was notified by the facility on 2/25/26 at approximately 9:30 a.m. about the abuse allegation and began an investigation. The investigation's conclusion indicated that CNA BB's contracted travel employment at the facility was terminated on 2/25/26, and her travel employment agency was notified that she was no longer permitted on the facility's premises. Resident 13's power of attorney (POA, a trusted person to act on your behalf regarding financial, legal, or medical matters), DON, administrator, and physician were notified of resident 13's injuries and the investigation. The Department of Human Services (DHS) and the SD DOH were both notified on 2/25/26. 2. On 5/26/26, a request for the facility's investigation documentation for 2/25/26 was made, and on 5/27/26 at 8:12 a.m., CEO A reported that the facility did not have any investigation documentation to provide. 3. Review of resident 13's electronic medical record (EMR) revealed she admitted to the facility on [DATE]. Her 12/30/25 Brief Interview of Mental Status (BIMS) assessment score was 4, and her 3/24/26 BIMS assessment score was 7, both of which indicated her cognition was severely impaired. Resident 13 was discharged on 4/2/26 due to her death in the facility. A 2/24/26 6:35 a.m. nursing progress note documented by contracted travel RN T (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	revealed that staff reported to this writer that resident [13] had 3 large purple bruises on the right forearm. The bruise closest to the wrist has a small skin tear. One purple bruise on [the] left forearm. Left side of lip has a small cut. Resident states, ?She grabbed my arm and twisted it.' DON, ADON [assistant DON] notified. Resident 13's 2/24/26 12:57 p.m. skin assessment indicated that she had 3 large purple bruises on her right forearm. The bruise closest to the wrist has a small skin tear. One purple bruise on her left forearm, and the left side of her lip has a small cut. Denies having pain, Turgor [the skin's elasticity used to check the body's hydration level] is > [greater than] 3 seconds. A 2/24/26 3:37 p.m. progress note indicated that contracted travel RN T was unable to reach resident 13's first emergency contact person but was able to reach her second emergency contact person by phone, and he would try to notify resident 13's first emergency contact person. A 2/25/26 1:16 p.m. progress note indicated that DON B attempted to call resident 13's first emergency contact to Follow up on [her] bruises, No answer, will try again later. There was no other documentation in resident 13's EMR that indicated resident 13's first emergency contact was notified of the abuse allegation on 2/24/26 that resulted in physical harm. A 3/8/26 physician's order indicated to observe bruising to bilateral forearms until healed, two times a day. Review of resident 13's most recent care conference summary was completed on 3/25/26, but no care conference signature form was available to review. There was no documentation in resident 13's EMR that the allegation of abuse with physical harm was reviewed with her family and the IDT team. Resident 13's care plan, dated 7/10/25 and revised on 3/30/26, did not address interventions that helped ensure her safety from abuse related to her cognitive or behavioral status. Incident tracking reports in the facility's electronic system (PCC) showed that no incident report for the abuse incident had been completed in the risk management report section from 2/16/26 through 3/16/26, as required by the facility's policy. 4. Review of the facility's staff schedules and timecards from 2/23/26 through 2/24/26 revealed that contracted travel CNA BB was assigned to resident 13 during the night shift on 2/23/26 at 5:17 p.m. through the morning of 2/24/26 at 6:21 a.m. 5. Review of contracted travel CNA BB's personnel file revealed that she was hired in January 2024 through a contracted travel agency. She completed abuse training through another facility on 4/13/23 and elder physical abuse and managing resident behaviors training with the provider on 9/8/25. No disciplinary actions or allegations of abuse and neglect were documented or found in former contracted travel CNA BB's file. 6. Interview on 5/27/26 at 3:37 p.m. with licensed social worker (LSW) E revealed the incident reports were completed by CEO A and DON B, and that she was not aware of resident 13's allegation of abuse on 2/24/26. LSW E did not believe she was notified of the incident involving resident 13 on 2/24/26 and acknowledged that she did not complete any documentation regarding the incident in resident 13's EMR. 7. Phone interview with resident 13's first emergency contact was attempted on 5/27/26 at 4:08 p.m.; a message was left for a return call. No return call was received during the survey. 8. Interview on 5/28/26 at 4:50 p.m. with CEO A revealed that CEO A acknowledged that no audits or education were provided to staff regarding resident abuse, and that no further follow-up was conducted with other residents to determine whether they were harmed by staff or felt safe at the facility. He said that resident incidents were routinely discussed in the Quality Assurance Performance Improvement (QAPI) and board meetings, and did not provide any further information on what those meetings determined regarding the incidents. 9. Interview on 6/1/26 at 12:08 p.m. with DON B revealed that she or CEO A initiated incident investigations. DON B acknowledged that no other residents were interviewed as a part of their investigation to assess additional concerns of abuse or neglect, no additional education on abuse prevention was provided to staff, and no audits related to the resident interviews and staff education were completed after the 2/24/26 incident involving resident 13. DON B further stated that approximately two weeks prior to resident 13's abuse allegation, she spoke to contracted travel CNA BB about toileting residents upon their requests, as it had been reported to her by staff that contracted travel CNA BB had told a resident, whom DON B could not recall, that she could not use the bathroom. DON B said she spoke with contracted travel CNA BB about that allegation, and contracted (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	travel CNA BB denied it. DON B said she reported the information to the contracted travel CNA BB's travel staffing company to inform them that the discussion about the resident's situation had been identified as a disciplinary matter involving contracted travel CNA BB. 10. Review of the provider's revised June 2021 job description for the long-term care (LTC) Certified Nurse Assistant (CNA) revealed that The CNA assists in the provision of nursing care of the residents as directed by the charge nurse. Care skills include but are not limited to: comfort and safety measures, personal hygiene, assisting with activities of daily living, and simple nursing procedures. The CNA's duties include: Assisting residents with activities of daily living (ADLs) such as bathing, dressing, and grooming, responding to patient call lights and anticipating resident needs, maintaining a safe and orderly environment, following established health and safety standards, and coordinating with nurses and other healthcare professionals to ensure comprehensive and consistent patient care. CNAs will Demonstrate knowledge of the principles of growth and development over the life span and the skills necessary to provide age-appropriate care. Demonstrate appropriate lifting, repositioning, and moving of residents. Reports resident concerns, and promotes a safe and hazard-free resident care environment. 11. Review of the provider's reviewed December 2021 Abuse Prohibition policy revealed that the facility was To utilize the abuse prohibition investigative protocol to be in compliance with federal regulations. Documentation is required for all suspicious injuries, bruises, skin tears, fractures, and injuries of unknown origin. The primary RN or DON will complete necessary documentation surrounding the injury using the Injury Assessment form. Abuse, involuntary seclusion, and misappropriation of property will be reported to the primary registered nurse (RN) and then to the director of nursing (DON) or social worker who will be responsible for initial investigation of the incident. Document the investigation by using the Grievance Complaint Investigation form, and place it with the investigation report. 12. Review of the undated admission packet revealed that The facility will notify the resident or representative when an accident or injury occurs. Complaints of abuse, harassment, or mistreatment will be immediately investigated and you [the resident or resident's representative] will receive a written and/or verbal report of the findings, and/or corrective actions taken within five working days of filing the report.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, observation, document review, record review, and policy review, the provider failed to report within the required time frame to the SD DOH for two of two sampled residents' (5 and 13) allegations of potential resident abuse or neglect. Findings include:1. Review of the provider's 12/23/25 SD DOH FRI report revealed that on 11/19/25, it was reported that resident 5 spilled her hot tea in the dining room, which resulted in a 0.25 centimeter (cm) blister on her right inner thigh, and both inner thighs were red. Bacitracin (an antibiotic ointment) was applied to the blister, and it was covered with a bandage. Resident 5 told a family member that a staff member spilled the hot tea on her. On 12/22/25, resident 5's family member told registered dietitian (RD) H that she thought that a staff member spilled the hot water on resident 5. On 12/22/25, chief executive officer (CEO) A and director of nursing (DON) B interviewed resident 5, and resident 5 provided inconsistent information about who spilled the hot water for her tea. The provider determined the incident was not the result of abuse or neglect. The report indicated that the provider, family, and DON were notified of the incident. 2. A request was made to CEO A on 5/27/26 at 9:00 a.m. for the provider's reporting and investigating policies and incidents subject to reporting. A request was made to DON B on 5/27/26 at 3:00 p.m. for the provider's incident reporting guidelines and abuse and neglect policies. 3. Interview on 5/27/25 at 2:20 p.m. with licensed social worker (LSW) E and social services designee (SSD) revealed SSD F read about resident 5's 11/19/25 hot liquid burn injury the following day (11/20/25) in the nurse's progress note. At that time, it was documented that resident 5 spilled her coffee in her lap. She could not recall when she learned that resident 5's daughter stated that she thought the hot liquid burn injury was caused by a staff member. She could not recall when she learned that resident 5's daughter stated that she thought the hot liquid burn injury was caused by a staff member. LSW E became aware of resident 5's family members' concern that resident 5 received a hot liquid burn injury and that resident 5's family member thought that a staff member caused that burn injury on 12/23/25. LSW E was unaware when resident 5's family member first shared the concern that the hot liquid injury was caused by a facility staff member. She expected that if resident 5's family member shared a concern that she thought that a staff member caused resident 5's burn injury, that concern would have been reported to CEO A and DON B immediately, and CEO A or DON B would have reported the incident to the SD DOH. She expected that CEO A and DON B would have been responsible for filing a report, investigating the incident of concern, and sharing the outcome of their investigation with the family member for a family member's concern that was required to be reported to SD DOH. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Continued interview on 5/27/26 at 3:37 p.m. with LSW E revealed that she completed the SD DOH FRI investigation and reports until she began working remotely about two years ago and now CEO A and DON B were responsible for reporting and investigating incidents. She worked at the facility two days per month. She recalled that DON B called her several weeks after resident 5 received a hot liquid burn injury from her tea, because a family member complained to the RD H that staff spilled coffee on resident 5. That incident was originally documented on 11/19/25 by the nurse that resident 5 spilled her hot beverage on herself, and an investigation was not completed. LSW E advised DON B to report the 11/19/25 hot liquid burn injury incident to the SD DOH. 5. Phone interview on 5/27/26 at 4:34 p.m. with resident 5's family member regarding resident 5's 11/19/25 hot liquid burn injury incident revealed she visited resident 5 on 11/24/24 and was told by resident 5, they burned me, and resident 5 showed her the inner thigh area. She was resident 5's emergency contact, and no notification was provided to her or the other listed emergency contact. It had been about a week since that incident occurred. While at the facility on 11/24/25, she spoke with a nurse (she was unable to recall who she spoke with) about the incident and was told that the documentation in resident 5's EMR said that resident 5 spilled her own coffee in her lap and that the emergency contact was notified. She stated that resident 5 was coherent, repeated several times, they burned me, and that she believed resident 5. She told the nurse that she thought a staff member caused resident 5's burn injury and that she was upset that she and the other emergency contact were not notified. Resident 5's family member attended the 12/9/24 care conference meeting and told the staff members that she was concerned that a staff member caused resident 5's burn, and that she and the emergency contact were not notified. She recalled that RD H was present at that care conference and said she would check into it. On 11/23/25, she stopped to visit with RD H because she was not provided any additional information about what happened when resident 5 was burned or what the facility was doing about it. She was frustrated that the facility did not follow up with her about her concerns and stated that she hoped that an incident like this would not happen again or happen to anyone else. 6. Review of resident 5's 12/9/25 Care Conference Assessment revealed that resident 5, her family member, RD H, assistant DON C, and SSD F attended that care conference. Resident 5's family member discussed her concerns about resident 5's burn injury from her hot tea. 7. A request was made to DON B on 5/28/26 at 8:30 a.m. for the provider's accident hazards policy. The provider provided their reviewed December 2021 Abuse Investigating policy and their revised January 2020 Accidents and Incidents policy. 8. Interview on 6/1/26 at 12:17 p.m. and again on 6/2/25 at 11:31 a.m. with DON B regarding resident 5's 11/19/25 hot liquid burn injury revealed that she was notified on 12/22/25 that resident 5's family member was stating that resident 5 was burned by hot liquid and that she thought that a staff member caused the burn injury. She was not notified on 11/19/25 that resident 5 received a hot liquid burn injury, and did not expect to be notified because it was not serious enough to require a visit to the emergency room, and staff thought that she had spilled her hot tea on herself. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She expected the staff in attendance at resident 5's care conference on 12/9/25 would have notified her immediately after resident 5's family member expressed concern that resident 5 was burned by a staff member, so she could have investigated and reported the incident to the SD DOH. Due to the staff not immediately reporting the incident to her, there was a delay in the investigation and reporting of resident 5's hot liquid spill that resulted in a burn, which required treatment. DON B reported resident 5's 11/19/25 hot liquid burn injury to the SD DOH on 12/23/25. She thought allegations of resident abuse or neglect needed to be reported within 24 hours and that her investigation needed to be completed within 5 days. She was not aware that an allegation of resident abuse or neglect needed to be reported within 2 hours. 9. Interview on 6/2/26 at 8:25 a.m. with RD H regarding resident 5's 11/19/25 hot liquid burn injury revealed she learned of the injury during resident 5's 12/9/25 care conference. Resident 5's family member was concerned that resident 5 was burned by hot tea in the dining room, thought that a staff member spilled the hot tea on resident 5, wanted to know more about how the incident occurred, and what steps were taken to prevent it from happening again. RD H stated that she followed up with dietary manager (DM) G, SSD F, and DON B by email after the care conference about the actions that DM G was taking. On 12/23/25, resident 5's family member came to her office, and RD H told her about the implemented interventions. She was unaware whether the incident had been investigated and reported to the SD DOH. 10. Interview on 6/2/26 at 9:48 a.m. with SSD F revealed that she attended resident 5's 12/9/25 care conference and was aware that resident 5's family member was concerned about how resident 5 was burned by her hot tea, but it was documented that resident 5 spilled her tea on herself. She was unsure if a report should have been made to the SD DOH. She was unaware that resident 5's family member had more concerns about resident 5's hot liquid burn injury or how it happened. 11. Review of the SD DOH Facility Reported Incident dated 2/25/26 revealed an allegation of staff abuse by a former contracted travel certified nursing assistant (CNA), BB, against former resident 13 on 2/24/26. On the morning of 2/24/26, at around 6:00 a.m., an unidentified CNA entered resident 13's room to assist her with her morning care. The CNA noted that resident 13 had bruises and a skin tear to her right forearm. The CNA reported her findings to the on-duty unidentified registered nurse. The nurse assessed resident 13 and confirmed that she had bruises on both arms and a skin tear on her right arm. Resident 13 told the CNA and RN that a girl from the night shift was mean, grabbed her arm, and wanted her to get out of bed to go to the bathroom. Resident 13 told the girl (from the night shift) that she had already gone to the bathroom and said no, but the girl had made her get up out of bed. The incident, along with the noted bruising and skin tear, was reported to director of nursing (DON) B upon her arrival at work that same day. On the evening of 2/24/26, DON, B, and the chief executive officer (CEO) A met with the contracted travel CNA BB, to discuss resident 13's abuse allegation. Contracted travel CNA BB explained that she was assisting resident 13 in getting ready for bed on the evening of 2/23/26. While helping resident 13 stand, resident 13 began to fall, contracted travel CNA BB grabbed resident 13 by both forearms to steady her, which may have caused the bruising. Contracted travel CNA BB also stated that when she went in to assist resident 13 with care early the next morning on 2/24/26, resident 13 was combative, but contracted travel CNA BB said she was able to reason with resident 13 and left her room when resident 13 told her to. Contracted travel CNA BB wrote a statement about the incident (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be immediately investigated and you will receive a written and/or verbal report of the findings, and/or corrective actions taken within five working days of filing the report. 25. Review of the provider's revised January 2020 Accidents and Incidents policy revealed .all accidents or incidents occurring on our premises must be reported to the administrator. Regardless of how minor an accident or incident may be, it must be reported to the department supervisor and an Accident or Incident Report Form must be completed on the shift that the accident or incident occurred. The Investigation Report Form must be submitted to the Director of Nursing Services no later than twelve (12) hours after the occurrence of the accident or incident. Submit the original copy of the Investigation Report and the Accident and Incident Report to the Administrator no later than 24 hours after the occurrence of the accident or incident. The policy did not address reporting timelines for reporting incidents, accidents, or suspicion or allegations of resident abuse or neglect to the SD DOH.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** A. Based on observation, interview, record review, and policy review, the provider failed to ensure resident safety by not assessing the side rails/grab bars and mattresses on the resident's beds for entrapment (trapped between the rail, mattress, or bedframe spaces) for four of six sampled residents (17, 21, 25, and 26) with loose side rails/grab bars on their beds, five of six sampled residents (6, 14, 17, 21, and 25) with an unsecured mattress on their bed, and one of six sampled residents (17) with a side rail/grab bar that was not indicated for use on the bed. Those failures put those residents at risk for entrapment, injury, or harm.Immediate Jeopardy (IJ) at F689, with a scope and severity of K, began on 5/28/26 at 10:05 a.m. upon observation of resident 14's bed. The bed was unlocked and moved away from the wall; the mattress slid away from the side rail/grab bar with minimal effort, creating a gap of more than five inches. The bed frame did not have mattress guards, which held the mattress in place, preventing the mattress from sliding when a side rail/grab bar was on the bed, putting the resident at risk for entrapment, injury, or harm.Chief executive officer A and director of nursing (DON) B were notified of the IJ on 5/28/26 at 12:45 p.m., and a removal plan was requested. The edited removal plan was received on 5/28/26 at 3:03 p.m. and was accepted on 5/28/26 at 5:10 p.m.The IJ was removed on 5/28/26 at 5:25 p.m. as confirmed by onsite verification by the survey team. After the IJ removal, the severity of non-compliance remained at a G.Current census was: 27Findings include: 1. Observation on 5/27/26 at 9:52 a.m., with resident 6 and resident 14 in their shared room, revealed that a right-side rail/grab bar was attached to each bed. Their mattresses were not securely attached to the beds and created a gap between the side rails/grab bars and the mattresses when the mattresses moved. The gap between resident 14's bed and the side rail/grab bar measured four and a half inches when the mattress slid to the wall when touched. 2. Observation on 5/27/26 at 9:53 a.m. with resident 17 in her room revealed that she had a side rail on the left side of her bed, which was up against a wall in her room. The side rail was loose and could be pulled away from the bed. It was not properly attached to the bed and was held in place with a zip tie. The side rail's bar was not attached to the frame of the bed, was unsecured under the mattress, and could move around. 3. Observation on 5/27/26 at 9:54 a.m., with resident 26 in his room, revealed he had side rails/grab bars on both sides of his bed. The rail/grab bar on the right-handed side of the bed was loose and moved approximately four inches away from the mattress when touched. 4. Observation on 5/27/26 at 10:06 am, with resident 21 in his bed, revealed that he had a rail on the right side of his bed, which was loose, with a four-inch gap between the loose rail and his mattress. The left side of his bed was up against the wall. 5. Observation and interview on 5/27/26 at 9:58 a.m. with resident 25 in his room revealed that he had side rails on both sides of his bed. The right-side rail was loose and could be pulled away from the bed. The left side of the bed was positioned against the wall. Resident 25 was lying in bed with his head resting against the left side rail. He did not use the side rails for transferring in or out of bed or repositioning while he was in bed. There was a gap between the headboard and the head of the mattress that was unable to be measured at that time with resident 25 lying in the bed. 6. Observation on 5/27/26 at 12:04 p.m. of resident 25's bed revealed there was a five-inch gap (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	between the top of the mattress and the headboard. The loose rail on the right side moved four inches away from the mattress when pulled on. The left side rail was securely attached to the bed. 7. Review of resident 25's electronic medical record (EMR) revealed he admitted to the facility on [DATE]. He had a Brief Interview of Mental Status (BIMS) assessment score of 15, which indicated his cognition was intact. His diagnoses included alcohol induced dementia (a group of symptoms affecting memory, thinking, and social abilities caused by excessive prolonged use of alcohol), and an eye movement disorder. His 5/28/26 care plan indicated that resident 25 was unable to see out of his left eye. Resident 25's 1/9/24 side rail and safety screen indicated bilateral side rails were recommended to be installed by occupational therapy due to [Resident 25] was using bed rails in [the] hospital. Without them he requires increased assistance. Recommending Bilateral [bed] rails. There was no documentation that indicated when resident 25's side rails were installed. A 10/8/25 progress note indicated resident 25 fell on his face over his bed hitting the headboard and lacerating [cutting] his nose on the right side. He was sent to the emergency room for further assessment. 8. Observation on 5/27/26 at 12:05 p.m. of the bed in resident 21's room revealed the gap between the loose rail on the right side of the bed and his mattress measured five inches when the mattress slid to the wall and the loose rail was pulled out from the bed. The gap measured four and a half inches between his headboard and the head of the mattress. 9. Interview and observation on 5/28/26 at 10:05 a.m., with DON B in resident 14 and 6's shared room revealed she was unaware that the side rails/grab bars and mattresses needed to be assessed for entrapment risks. She was unsure if maintenance assessed the side rails or mattresses for entrapment risk in any zones [specific areas around a hospital bed where a resident's head, neck, or chest can get wedged]. When a resident or their representative requested a side rail/grab bar, the therapy department would assess the resident using a checklist. The checklist did not contain resident risk for entrapment, any interventions tried before the use of the side rail/grab bar, or indicate that the resident's consent for the use of the side rail/grab bar was needed. She thought that if a resident wanted a side rail/grab bar, they could request one, and one would be provided. Resident 14's bed was not locked, the bed was moved away from the wall, and the mattress slid away from the bed rail with minimal effort when pushed, which created a large gap of more than five inches. She confirmed that the bed did not have the mattress guards to hold the mattress in place and prevent the mattress from sliding when a side rail/grab bar was attached to the bed frame. Resident 6's bed did not have the mattress guard. She confirmed that resident 14 and resident 6's beds had potential risks for entrapment between the side rail/grab bar and the mattresses. 10. Review of the maintenance clipboard in the charting conference room revealed there were no resident beds or side rail repair requisitions from 3/18/26 through 5/28/26. 11. Interview on 6/1/26 at 11:56 a.m. with DON B revealed there was no documentation available related to when the side rails were installed on the residents' beds. 12. Interview and review of the maintenance Inspection of Bed Frame w[with]/Mattress and Side (continued on next page)

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