STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435070	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Sister James Care Center	2111 West 11th Street Yankton, SD 57078

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	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), observation, interview, record review, and policy review, the provider failed to ensure the staff used assistive safety devices for one of one resident (1) who fell, suffered a broken nose, and required emergency room treatment, while ambulating to a meal when one of one certified medication aide (E) failed to use a gait belt (a waist strap gripped as support for safe mobility and transfers) while assisting resident 1 with ambulating (walking).Findings include: 1. Review of the 1/28/26 SD DOH FRI regarding resident 1 revealed:*He was ambulating to the dining room.*He tripped over his feet and fell forward hitting his head on a table and landed on the floor.*CMA E was walking with the resident, but did not use a gait belt.*He was sent to the emergency room for evaluation.*He had a nasal bone fracture (broken nose) and multiple skin tears on his face and arms. 2. Observation and interview on 2/4/26 at 9:10 a.m. with resident 1 in his room revealed:*He had multiple cuts and bruises on his face and arms from a recent fall.*He used his walker to help keep his balance when he walked.*He stated he got ahead of himself and was going too fast when he tripped and fell on his way to the dining room.*A staff member was walking with him when he fell. 3. Interview on 2/4/26 at 2:25 p.m. with CMA F revealed:*A gait belt was used when transferring or walking with a resident unless they were independent.*The therapy department would evaluate the residents to determine the level of supervision for transfers and walking.*Resident 1 was an assist of one (needed one staff member to assist him with walking) according to his care plan (personalized plan that addresses a resident's care needs, goals, and interventions) so he would use a gait belt when walking with him. 4. Interview on 2/4/26 at 2:35 p.m. with CMA E revealed:*She was walking with resident 1 to the dining room when he fell.*She knew he was an assist of one with ambulation.*He started walking too fast and his walker was too far out in front of him.*She asked him to slow down.*She did not use a gait belt while walking with resident 1.*He tripped over his own feet and fell into the table and hit his head.*She was educated on gait belt use after that incident. 5. Review of resident 1's electronic medical record (EMR) revealed:*He was admitted on [DATE].*His Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated he was cognitively intact.*His admitting diagnosis included congestive heart failure (CHF), weakness, and hyponatremia (low blood sodium levels).*His care plan indicated:-I am at risk for falls due to [use of] high-risk meds, morbid obesity, impaired mobility, [and] need for assistance.-I will have no falls in the next 90 days.-Ensure [my] call light [is] in reach [while I am] in [my] room.-Fall safety rounds (staff checking on residents on a routine basis).-Walker with gait belt [and] 1 assist.-W/C [wheelchair] with foot pedals on for distance.-Cue resident to slow down when ambulating*His fall risk assessments completed on 12/1/25, 12/4/25, 12/21/25, 12/31/25, 1/22/26, and 1/28/26 indicated that resident 1 was at a high risk for falling. 6. Interview on 2/4/26 at 3:45 p.m. with physical therapist D revealed:*She assisted resident 1 with therapy and his therapy services ended 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435070	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Sister James Care Center	2111 West 11th Street Yankton, SD 57078

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	1/22/26.*He was discharged from therapy with instructions for contact guard assist of one with a gait belt (a staff member would walk with him, and he would have a gait belt on).*He was on a walk to dine program (staff would walk with him to and from meals).*She expected that the staff would use a gait belt when resident 1 was walking. 7. Interview and review of resident 1's care plan on 2/6/26 at 8:30 a.m. with registered nurse (RN) C revealed:*She confirmed resident 1 had a walker, a gait belt, and was a one assist on his care plan.*That care plan information was transferred to the staff daily sheets (printed information with resident care needs).*She expected the staff to use a gait belt when resident 1 was ambulating.*Education was provided to the staff after his 1/28/26 falling incident. 8. Interview on 2/6/26 at 10:30 a.m. with administrator A and director of nursing (DON) B revealed:*They expected staff to follow the resident's care plan.*They agreed CMA E should have used a gait belt when walking with resident 1.*Education was provided to the staff regarding gait belt use and following the care plan.*Gait belt audits were being completed. Review of the provider's February 2026 SJCC [Sister [NAME] Care Center] Gait Belt- LTC [Long Term Care] policy revealed Gait belts will be used for any resident who requires assistance with transfers and/or ambulation. Review of the provider's revised October 2024 LTC Falls and Accidents-System Standard policy revealed:*C. Review of individualized, resident-centered interventions, including adequate supervision and assistive devices, to reduce individual risks related to hazards in the environment must occur. The plan of care must be updated/modified accordingly.