STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435078	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Eureka Health Care Center	202 J Avenue Eureka, SD 57437

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure the code status (emergent treatment a person wishes to receive if their heart or breathing would stop) for ten of ten sampled residents (5, 6, 7, 8, 12, 22, 31, 39, 40, and 45) was documented in the residents' electronic medical records (EMR). Findings include: 1. Review of resident 7's EMR revealed she admitted to the facility on [DATE]. Her 4/24/26 Minimum Data Set (MDS) assessment indicated that she was rarely understood or able to understand others and was severely cognitively impaired. There was no documentation indicating that any advance directive (a document that expresses a person's health care wishes if they become unable to speak for themselves) paperwork was completed upon admission. A copy of her Durable Power of Attorney (someone designated on a legal document to act on behalf of a resident) was scanned into the Meditech EMR, but it did not address her code status. A 5/18/26 physician's order indicated her code status was DNR/DNI. There was no physician documentation supporting that code status order or indicating that her wishes were discussed with the resident or the resident's representative. 2. Review of resident 8's EMR revealed she admitted to the facility on [DATE]. Her 3/27/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. There was no documentation indicating that any advance directive paperwork was completed upon admission. A 5/18/26 physician's order indicated her code status was DNR/DNI. There was no physician documentation supporting that code status order or indicating that her wishes were discussed with the resident or her representative. 3. Review of resident 22's EMR revealed he admitted to the facility on [DATE]. His 4/6/26 BIMS assessment score was 00, which indicated his cognition was severely impaired. A 5/18/26 physician's order indicated his code status was DNR/DNI. There was no completed code status form in his EMR to indicate his wishes if his heart or breathing stopped. There was no documentation in his EMR that his wishes were reviewed with him or his representative. 4. Review of resident 40's EMR revealed he admitted to the facility on [DATE]. His 6/12/26 BIMS assessment score was 11, which indicated his cognition was moderately impaired. A 5/18/26 physician's order indicated his code status was DNR/DNI. There was no completed code status form in his EMR to indicate his wishes if his heart or breathing stopped. There was no documentation in his EMR that his wishes were reviewed with him or his representative. 5. Review of resident 12's EMR revealed he admitted to the facility on [DATE]. His 6/12/26 BIMS (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment score was 00, which indicated his cognition was severely impaired. A 5/18/26 physician's order indicated his code status was DNR/DNI. There was no completed code status form in his EMR to indicate his wishes if his heart or breathing stopped. There was no documentation in his EMR that his wishes were reviewed with him or his representative. 6. Review of resident 39's EMR revealed he admitted to the facility on [DATE]. His 6/12/26 BIMS score was 5, which indicated his cognition was severely impaired. A 5/18/26 physician's order indicated his code status was DNR/DNI. There was no completed code status form in his EMR to indicate his wishes if his heart or breathing stopped. There was no documentation in his EMR that his wishes were reviewed with him or his representative. 7. Review of resident 6's EMR revealed he admitted to the facility on [DATE]. His 3/10/26 BIMS assessment score was 00, which indicated his cognition was severely impaired. A 5/18/26 physician's order indicated his code status was DNR/DNI. Her EMR banner indicated her code status was DNR/DNI. His 7/13/20 Durable Power of Attorney indicated, I direct that life-prolonging treatment be withheld or withdrawn and that I be permitted to die naturally if two physician's certify that: (a) I am in a terminal condition that is an incurable or irreversible condition which, without the administration of life-prolonging treatment, will result in imminent death; (b) The application of life-prolonging treatment would serve only to artificially prolong the process of my dying; and It is my intention that this declaration be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and that they accept the consequences of that refusal, which is death. There was no documentation in resident 6's EMR to indicate that two physicians had certified his condition to be terminal or incurable. 8. Review of resident 5's EMR revealed he admitted to the facility on [DATE]. His 5/12/26 BIMS assessment score was 14, which indicated his cognition was intact. A 5/18/26 physician's order indicated his code status was to be a full code (all resuscitation measures were to be implemented). His EMR banner indicated his code status was to be full code. There was no completed code status form in his EMR to indicate his wishes if his heart or breathing stopped. There was no documentation in his EMR that his wishes were reviewed with him or his representative. 9. Review of resident 31's EMR revealed she admitted to the facility on [DATE]. Her 4/7/26 BIMS assessment score was 00, which indicated her cognition was severely impaired. A 5/18/26 physician's order indicated her code status was DNR/DNI. Her EMR banner indicated her code status was DNR/DNI. Her 2/10/18 Living Will indicated, Provide life-sustaining treatment only if I have detectable brain activity, and there is a reasonable possibility of restoring to me the ability to thinks and act for myself. If my heart stops, provide restoration treatment until there is no hope of regaining a heartbeat. There was no documentation in her EMR that her wishes had changed since she signed her Living Will on 2/10/18. 10. Review of resident 45's EMR revealed she admitted to the facility on [DATE]. Her 4/7/26 BIMS assessment score was 0, which indicated her cognition was severely impaired. A 5/18/26 physician's order indicated her code status was DNR/DNI. There was no completed code status form in her EMR to indicate her wishes if her heart or breathing stopped. There was no documentation in her EMR that her wishes were reviewed with her or her representative. 11. Interview on 6/11/26 with director of nursing (DON) B revealed there was no documentation in (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents' 5, 6, 7, 8, 12, 22 31, 39, and 45 EMRs to support their code status that was indicated on their EMR banners were discussed with that resident or the resident's representative to be sure the resident's wishes would be followed if their heart or breathing stopped. The provider did not have documentation that two physicians had certified that resident 6 had a terminal condition that was incurable or irreversible, as his Durable Power of Attorney indicated was his wish. She acknowledged that the staff could not determine if resident 31 had brain activity, or if there was a reasonable possibility of restoring her to the ability to think or act by herself when her breathing or her heart stopped as her Living Will stated was her wish. 12. Review of the provider's October 2025 Code Status/Resuscitation policy revealed that when a resuscitation decision has been made, the physician was responsible for documenting in the chart the rationale supporting the physician's order for resuscitation status. The physician also must document the risks, benefits, and choices that were discussed with the resident and with the family.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure the manufacturer's instructions were followed for the installation of assistive devices (T Shaped poles attached to the residents' bed frames to be used for bed mobility) to the residents' beds, alternatives to the assistive devices were attempted before the assistive devices were installed, and the date of installation was documented for nine of nine sampled residents (1, 9, 10, 32, 34, 35, 36, 43, and 47), a physician's order was obtained before the installation of the assistive device for five of nine sampled residents (1, 9, 32, 34, and 47), a safety assessment was completed for four of nine sampled residents (1, 9, 34, and 35), and informed consent was obtained for the use of the assistive device for two of nine sampled residents (9 and 34) who had assistive devices on their beds.Findings include:1. Observation and interview on 6/9/26 at 10:03 a.m. with resident 9 in her room revealed that she had an assistive device attached to the right side of her bed, which she used to reposition herself in bed. She was unsure whether she was educated about the risks and benefits of the assistive device. Review of resident 9's electronic medical record (EMR) revealed she admitted to the facility on [DATE]. There was no documentation of prior interventions attempted before her assistive device was installed, a signed consent, a physician's order for the use of the assistive device, or a quarterly assessment completed to assess her safe use of the assistive device. There was no documentation of the date the assistive device was applied to her bed. 2. Observation on 6/9/26 at 10:04 a.m. in resident 34's room revealed she had an assistive device attached to the left side of her bed. Review of resident 34's EMR revealed she admitted to the facility on [DATE]. There was no documentation of prior interventions attempted before her assistive device was installed, a signed consent, a physician's order for the use of the assistive device, or a safety assessment completed to assess her safe use of the assistive device. There was no documentation of the date the assistive device was applied to her bed. 3. Observation on 6/9/26 at 10:24 a.m. in resident 35's room revealed there was an assistive device attached to the left side of his bed. Review of resident 35's EMR revealed that he admitted to the facility on [DATE]. There was no documentation of prior interventions attempted before his assistive device was installed, nor of a safety assessment completed to evaluate his safe use of the device. There was no documentation of the date the assistive device was applied to his bed. 4. Observation on 6/9/26 at 10:38 a.m. in resident 43's room revealed that she had mobility bars on the left and the right side of her bed. The bed rail was attached to the bottom of the bed frame with a pole coming up vertically from that bed frame. The vertical pole had a horizontal pole on it to make a T shape. The right vertical bar had a gap of 30 inches from the head of her bed to that vertical pole, while the left vertical bar had a gap of 23.5 inches from the head of her bed to that vertical pole. The right horizontal bar had a gap of 6 inches from the top of the mattress to the bar while the left horizontal bar's gap was 7 inches. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident 43's electronic medical record (EMR) revealed that she was admitted on [DATE]. She had a 7/22/22 physician's order for the bed rail. She had signed consent for placement of the bar on 11/22/22 and that consent listed risks and benefits of bed rail use. The provider could not provide documentation that alternatives were tried before use of the bed rail, an entrapment risk assessment was completed, or the date that the bed rail was applied. 5. Observation on 6/9/26 at 10:38 a.m. in resident 10's room revealed that she had mobility bars on both sides of her bed. The gap from the head of the bed to the vertical bar on the right side of her bed was 29 inches. That bed rail had a gap of 9 inches from the top of her mattress to the vertical rail. The bed rail was able to move 3 inches when it was shaken from the direction of the top of the bed to the foot of the bed. From side to side, that rail was able to move 1.5 inches. Review of resident 10's EMR revealed that she was admitted on [DATE]. She had a 7/29/22 physician's order for the bed rail. She had signed a consent for the placement of the bar on 11/22/22. That consent listed risks and benefits. The provider could not provide documentation that alternatives were tried before use of the bed rail, an entrapment risk assessment was completed, or the date that the bed rail was applied. 6. Observation and interview on 6/9/26 at 3:11 p.m. with resident 1 in his room revealed he had assistive devices attached on both sides of his bed, which he used to get in and out of bed. Review of resident 1's EMR revealed that he admitted to the facility on [DATE]. There was no documentation of prior interventions attempted before the assistive devices were installed, no physician's order for the use of the assistive devices, and no safety assessment was completed to evaluate his safe use of the device. There was no documentation of the date the assistive devices were applied to his bed. 7. Observation and interview on 6/9/26 at 4:01 p.m. in resident 36's room revealed that she had a bed rail on the right side of her bed that she used to get her from a seated to a standing position. She could not recall if she had been assessed or educated on the use of those bed rails. Review of resident 36's EMR revealed that she was admitted on [DATE]. She had a Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated that her cognition was intact. She had a 2/7/23 provider's order for the use of a mobility device, with the comment assist pole to the right side of bed to assist with bed mobility. The provider could not provide documentation that alternatives were tried before use of the assistive device, or the date that the assistive device was applied. 8. Review of resident 47's EMR revealed that she was admitted on [DATE]. She had a 10/2/25 nursing note that indicated that she had requested a nurse apply an assistive device for help with mobility in bed. The note indicated that a consent was signed for a left bed assistive device. The provider could not provide documentation that alternatives were tried before the assistive device was installed, a physician's order for use of an assistive device, or the date that the assistive device was installed on her bed. 9. Review of resident 32's EMR revealed that he was admitted on [DATE]. He had a signed consent for the use of a left assistive device on 9/8/23 that listed the risks and benefits of having an assistive device attached to the bed. The provider could not provide documentation that alternatives were tried before use of the assistive device, a signed physician's order for the device, or the date (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that the device was installed on his bed. 10. Interview on 6/11/26 at 10:46 a.m. with licensed practical nurse (LPN) E regarding resident assistive devices revealed that the nursing staff was responsible for obtaining the resident's consent, going over risks and benefits, assessing the safety risk, documenting alternatives, and obtaining a physician's order prior to a resident getting an assistive device installed on their bed. She was aware that some of the assistive devices were able to move and that they were not supposed to move. If they moved, nursing was expected to put in a work order for the maintenance staff to assess the assistive device. She was also aware that some of the residents' assistive devices were able to be lifted off the bed mount. She could not recall if staff received any education regarding the new assistive devices because they were purchased and applied several years ago. 11. Interview on 6/11/26 at 2:50 p.m. with facilities coordinator I revealed that he would get the approval from director of nursing (DON) B before applying an assistive device to a resident's bed. He did not like the mount that came with that assistive device to mount it to the resident's bed securely, so he made his own mount bracket to apply the bar to the resident's bed. The nursing staff performed the safety assessments. He was aware that the assistive devices were able to be moved in different positions depending on the resident's physical needs. He was not aware that some of the assistive devices were able to be lifted completely off the mount that kept them attached to the resident's bed. 12. Interview on 6/11/26 at 4:21 p.m. with DON B revealed that she was not aware that the current assistive devices were not compatible with the resident's current bed frames per the manufacturer's manual. She agreed this could cause a risk for entrapment. She agreed that there was no documentation that alternatives were attempted before applying the bed rails for any of the current residents with those bed rails. She could not provide documentation of the date that the bedrails were applied to the beds for residents 1, 9, 10, 32, 34, 35, 36, 43, and 47. 13. Review of the provider's April 2026 Physical Restrain/Bed Mobility Device policy revealed that gaps or widths between handles on devices must be less than 4 ¾ inches. When considering if a resident was appropriate for use of a bed rail, the least restrictive method will be tried first and the results documented. The policy also stated that bed mobility devices will not be offered as part of routine care and family or surrogates of [the] resident may not request [a] bed mobility device. A physician's order must be obtained for the use of the bed mobility device, and that device must be in the care plan, reviewed quarterly by the interdisciplinary team, and documented on the usage every shift. 14. Review of the 2012 Invacare CS Series Beds User Manual stated to only use Invacare rails.and other accessories with Invacare bed products and that the use of non-Invacare bed accessories may result in injury or death. In the bedrail entrapment risk notification section of the user manual, a bullet point read, Invacare homecare beds are specifically designed and manufactured for use in conjunction with Invacare accessories, including bed rails. The end of this section in the user manual noted that use of other manufacturer's products in conjunction with an Invacare homecare bed may significantly increase the risk of entrapment; as such Invacare does not recommend their use. 15. Review of the ER100 Bedside Balance Assist Rail installation instructions revealed that incorrect installation or incorrect use of ER100 can result in serious injury or death.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review, the provider failed to ensure one of one walk-in refrigerators were free from rust on the metal wire storage shelf that had flaked off and landed on the uncovered raw vegetables that were stored on that metal wire shelf. Findings include:1. Observation on 6/9/26 at 9:53 a.m. in the kitchen walk-in refrigerator revealed four metal wire shelves. The metal shelves had started to rust, and some rust flakes were on the floor. The bottom metal wire shelf had several cardboard boxes of raw vegetables including a box of onions with rust flakes. 2. Interview with food service manager J on 6/10/26 at 1:56 p.m. revealed he was aware of the rust on the metal wire shelves in the walk-in refrigerator. He stated that the rust can flake off those metal wire shelves and potentially land on uncovered raw foods such as vegetables. If the rust were to land on a vegetable like a broccoli stalk, then he would not be able to clean off the rust flakes, and they could potentially end up in the residents' meals. 3. Review of the provider's September 2025 Standard Food Storage Guidelines revealed that food storage areas should be clean to prevent contamination and illness to the residents.